THE TEXAS ABORTION BAN AND ITS DEVASTATING IMPACT ON COMMUNITIES AND FAMILIES

HEARING

BEFORE THE

COMMITTEE ON THE JUDICIARY
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

THURSDAY, NOVEMBER 4, 2021

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48–243 WASHINGTON : 2022

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THURSDAY, NOVEMBER 4, 2021

APPENDIX

THE TEXAS ABORTION BAN AND ITS DEVASTATING IMPACT ON COMMUNITIES AND FAMILIES

Thursday, November 4, 2021

HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY
Washington, DC

The Committee met, pursuant to call, at 12:09 p.m., in Room 2141, Rayburn House Office Building, Hon. Jerrold Nadler [Chair of the Committee] presiding.

Members present: Representatives Nadler, Jackson Lee, Johnson of Georgia, Bass, Jeffries, Cicilline, Raskin, Jayapal, Demings, Scanlon, Garcia, McBath, Stanton, Dean, Escobar, Ross, Bush, Jordan, Chabot, Gohmert, Issa, Buck, Johnson of Louisiana, Biggs, McClintock, Tiffany, Massie, Roy, Bishop, Fischbach, Spartz, Bentz, and Owens.

Staff present: Perry Apelbaum, Staff Director and Chief Counsel; Aaron Hiller, Deputy Chief Counsel; David Greengrass, Senior Counsel; John Doty, Senior Advisor; Moh Sharma, Director of Member Services and Outreach & Policy Advisor; Jordan Dashow, Professional Staff Member; Cierra Fontenot, Chief Clerk; John Williams, Parliamentarian and Senior Counsel; Merrick Nelson, Digital Director; Kayla Hamedi, Deputy Communications Director; James Park, Chief Counsel for Constitution; Will Emmons, Professional Staff Member/Legislative Aide for Constitution; Matt Morgan, Counsel for Constitution; Ella Yates, Minority Member Services Director; Betsy Ferguson, Minority Senior Counsel; Caroline Nabity, Minority Counsel; Elliott Walden, Minority Counsel; Andrea Woodard, Minority Professional Staff Member; and Kiley Bidelman, Minority Clerk.

Chair NADLER. The House Committee on the Judiciary will come to order. Without objection, the Chair is authorized to declare recesses of the Committee at any time.

Before we begin, I want to thank the Members and the Witnesses for their patience in delaying the start of the hearing. We welcome everyone to this morning's hearing on the Texas abortion ban and its devastating impact on communities and families.

Before we begin, I would like to remind Members that we have established an email address and distribution list dedicated to circulating exhibits, motions, or other written materials that Members might want to offer as part of our hearing today. If you would like to submit materials, please send them to the email address

that has been previously distributed to your offices and we will circulate the materials to Members and staff as quickly as possible.

I would also remind Members that guidance from the Office of Attending Physicians states that face coverings are required in all meetings and in closed spaces such as the Committee hearing except when you are recognized to speak.

I will now recognize myself for an opening statement.

Sixty-five days, that is how long women in Texas have been effectively stripped of their constitutional right to abortion. Earlier this year, Texas enacted Senate Bill 8, or SB 8 which bans abortions after six weeks of pregnancy before many people even know they are pregnant, thereby effectively blocking abortion access in the State entirely.

Although the law is clearly unconstitutional, its unique structure which relies solely on a private enforcement or really bounty system, has thus far allowed it to evade judicial review on the merits. SB 8 offers up a bounty, a minimum of $10,000 in legal fees to those who successfully bring a suit under the law's private cause of action provision. This provision permits any individual, not only abortion providers, but anyone who "aids or abets a violation of the abortion ban," a term so broad it would encompass practically any action from driving a patient to a clinic to merely offering personal advice.

This law created a perfect storm in Texas, which already has some of the most restricted abortion laws in the country because of the way it was written and because of its enforcement method. The Supreme Court had two opportunities to stop the law from taking effect during pending legal challenges and twice it failed to do so. As a result, communities and families in Texas have been devastated and the ban has had ripple effects to the State, around the region, and the country.

There is no question that SB 8 is blatantly unconstitutional, and that the Texas legislature intentionally ignore decades of legal precedent in enacting the law. To anyone who has been paying attention, this law did not appear out of nowhere. Rather, it is the result of a decade's long well-funded campaign by anti-abortion activists who steadily chip away at the right to abortion. These efforts have culminated in SB 8 and they have had one goal, to challenge and eventually to overturn the constitutionally-protected right to abortion.

Nearly 50 years ago, the Supreme Court recognized that right in *Roe* v. *Wade*. The Supreme Court has repeatedly upheld this critical constitutional right against legal challenge. Generations of Americans have come to rely upon the right to abortion to make the deeply personal decision about whether or when to have children. As the Supreme Court observed nearly 30 years ago when it reaffirmed the right to abortion in *Planned Parenthood* v. *Casey*, the ability of women to participate equally in the economic and social life of the nation has been facilitated by their ability to control their reproductive lives.

Access to safe, legal, and affordable abortion allows people to make choices about their own lives, when to start a new job, when to go back to school, and eventually when to start or grow a family. When the States chip away at, in the case of Texas newly banned

abortion access, they are not just controlling women's bodies, they are controlling their lives. That, in fact, falls most directly on communities of color, low-income women, and vulnerable populations.

This hearing occurs just days after the Supreme Court heard oral arguments in *Whole Woman's Health* v. *Jackson* and the *United States* v. *Texas*. Legal challenges to SB 8 were brought up by abortion care providers and the Department of Justice, respectively.

At the heart of these cases is the question of whether a State can effectively nullify the Constitution within its borders. SB 8 is designed to thwart a court's authority to review and potentially block a State law that prohibits the exercise of a constitutional right before it takes effect by delegating to private parties the authority to enforce the law. SB 8's bounty system, which is just as troubling as the six-week ban is meant to enforce, is a deliberate and disturbing effort by the Texas legislature to evade judicial scrutiny long enough for a clearly unconstitutional law to take effect. It worked.

SB 8's bounty system should be concerning to anyone who holds dear their constitutional rights. As Justice Kavanaugh, likely no fan of abortion rights, suggested during oral arguments on Monday, SB 8 could set a troubling precedent and a model for States to undermine not only abortion rights, but any constitutional right that a State legislature may disfavor, whether it be the right to free speech, the right to religious liberty, or the right to bear arms.

In addition, this perverse bounty system is designed to have a chilling effect on the ability of people to access abortion. Pregnant people in Texas may now be reluctant to confide in one's trusted neighbors, coworkers, or friends, or to seek help from organizations and advocates if they have questions. Providers have expressed confusion and concern about how to advise their patients and where to seek care for pregnancy complications.

The system was built to create fear, anxiety, and isolation for women and for providers in the State and in many ways, it has succeeded. SB 8 has not diminished the need for abortion in Texas or anywhere else in the country. People in Texas or particularly those in communities of color and low-income communities already face immense hurdles in accessing abortion.

In the last 20 years, Texas has passed some of the most extreme anti-abortion laws in the country. Even before SB 8, women were required to make multiple appointments, receive medically unnecessary sonograms, and listen to false and misleading anti-abortion propaganda. Because Texas bars any insurance, public or private, from covering abortion care, women must pay for this entire process out of their pocket which can cost anywhere from $300–$1200.

All of this assumes that they can even reach an abortion provider for more than 900,000 Texans of reproductive age live more than 150 miles from an abortion provider.

None of these rules and restrictions are science based or medically necessary. They are designed to stop women from accessing abortion and to control women's lives, plain and simple. Texas is not alone in enacting these restrictions. States around the country have passed similar laws and many now stand poised to pass copycat SB 8 laws as well.

These restrictions and laws make abortion almost completely inaccessible. They hit communities of color and low-income families the hardest. People who work hourly jobs, already have children, or lives miles away from an abortion provider face impossible decisions and often insurmountable obstacles in finding the time, money, and support to access care.

These steps and decisions take time, pushing people later into their pregnancy and making care more difficult to access and more expensive.

SB 8 has only exacerbated this situation. The need for abortion does not disappear in Texas under SB 8, even as the number of abortions provided in Texas has dropped by an estimated 50 percent. People are now seeking care out of State, traveling more miles, taking more days off of work, and spending much more money, all of this to get the care that they need, the care that they have a constitutional right to access, the care that is integral to their dignity and their fundamental freedom to live their lives on their own terms because ultimately the conversation about SB 8 and abortion rights is not a theoretical one.

As we will hear today, SB 8 and similar abortion restrictions are impacting real women and real families every day. I will stand with these women and with their providers. I will not stop fighting to protect the right to abortion and the right of every American to live their lives with dignity.

I thank our Witnesses for being here. I look forward to their testimony.

I now recognize the Ranking Member of the Judiciary Committee, the gentleman from Ohio, Mr. Jordan, for his opening statement.

Mr. JORDAN. Thank you, Mr. Chair. Mr. Chair, life is precious. Every single life is precious and worthy of protection and that fundamental principle is what the Texas law is about. It is what the pro-life movement is about. That is not what Democrats are about in Congress. Democrats are now trying to abandon the Hyde Amendment, language that has been in our law, been in any appropriation measure for the last 45 years which says that Federal tax money, the American people's tax money, will not be used to take the life of an unborn child. Even with the Hyde Amendment in place, over half a billion dollars in taxpayer funding is flowing to Planned Parenthood annually. Now, if the Hyde Amendment is actually repealed, as the Democrats seek to do, Planned Parenthood which does over 350,000 abortions per year will stand to get even more taxpayer money.

For decades, Democrats respected that those who oppose abortion would not have their tax dollars used to fund it. Now, they don't. Even President Biden changed his position. He used to be for the Hyde Amendment language. Now, he is not. That is how radical the Democrats' position has become on unborn children.

Republicans have numerous bills that would protect the unborn and it is our great hope that someday our colleagues on the other side of the aisle would consider moving those pieces of legislation. Let's be honest. Democrats aren't here to have an honest debate about the sanctity of life or the role of government protecting unborn children. Instead, they are here to play politics with our insti-

tutions and advance a radical leftist agenda. Right now, right now, there are three pro-life cases, three life cases before the Supreme Court. In this very week, the same week that the Chair chose to convene this hearing, the court held oral arguments on two of those cases.

Let's be clear. The Democrats have convened this hearing as a way to pressure the Supreme Court, to try to intimidate the Supreme Court. It is the play the Democrats use when the court was considering the census last Congress, sensationalize a legal question to delegitimize the court's role in interpreting the law.

Today, their focus is on this pro-life law in the State of Texas. Last year, while the court heard oral arguments in the case regarding a Louisiana pro-life law, Senator Schumer stood in front of the Supreme Court and said this. "I want to tell you Gorsuch, I want to tell you Kavanaugh, you have released the whirlwind and you will pay the price. You won't know what hit you if you go forward with these awful decisions."

If that is not threatening, if that is not trying to intimidate, I don't know what is. He did that in front of the Supreme Court that day. In April, Chair Nadler and other Democrat Members of this Committee made good on Senator Schumer's threat. They introduced legislation that would add justices to the Supreme Court, four associate justices, not one, not two, not three, but four. Why might they want four new justices? Because four new justices appointed by President Biden is the golden number for getting to a liberal majority on the court.

Even President Biden's Bipartisan Commission criticized this issue in their preliminary report last month. They wrote "Court expansion is likely to undermine, rather than enhance the Supreme Court's legitimacy and its role in the constitutional system. There are significant reasons to be skeptical that expansion would serve Democrat values."

That didn't deter congressional Democrats. After the release of the Commission's draft report, the Chair of this Committee and other Democrats promptly issued a statement condemning its finding, deriding President Trump, and doubling down on their plan. "We must pass legislation to expand the Supreme Court."

Just yesterday, Congressman Jeffries doubled down on Democrats' attack on the court tweeting, "The right wing majority on the Supreme Court is completely illegitimate." That statement doesn't make sense. I mean I think Mr. Gorsuch, Mr. Kavanaugh, Justice Coney Barrett, I think they were all nominated by the President, confirmed by the Senate. I think they are as legitimate as you can get under our constitutional system. Somehow the Democrats view that as illegitimate simply because they are pro-life.

Just so we are clear, the Chair of the House Judiciary Committee, the Committee charged by the American people with overseeing the judiciary and the Federal justice system in our country has introduced legislation to upset the balance of the Supreme Court all for political ends. This is just one branch of the government that Democrats don't control, and they can't stand it. The American people see through this all. The Texas law again is focused on the sanctity of life and protecting those who can't protect

themselves. That's what the pro-life movement is about. Life is previous and let's protect those who can't protect themselves.

Democrats in Congress are focusing on pressuring the court, intimidating the court, and packing the court, and the American people see it for what it is.

I want to thank our Witnesses for being here, especially Ms. Foster and for her work with Americans United for Life.

Mr. Chair, I yield back.

Chair NADLER. Without objection, all other—thank you, Mr. Jordan. Without objection, all other opening statements will be included in the record.

I will now introduce today's Witnesses.

Dr. Ghazaleh Moayedi is a board-certified OB/GYN and complex family specialist in Texas and Oklahoma. She is also the Founder and Chief Medical Officer of Pegasus Health Justice Center and serves as a board member of Physicians for Reproductive Health. Dr. Moayedi received her undergraduate degree from the University of Texas at Austin and completed her medical training at Texas College of Osteopathic Medicine in Fort Worth. She trained as an OB/GYN resident at Texas Tech Health Science Center in El Paso and completed her fellowship training in Complex Family Planning at the University of Hawaii where she also received her Master of Public Health degree in Health Policy and Management.

Khiara Bridges is Professor of Law at the University of California, Berkeley School of law. She previously taught at Boston University, Harvard Law School, Stanford Law School, and Yale School—good trinity—and served as the Center for Reproductive Rights Fellow at Columbia Law School. She received her B.A. from Spelman College and earned both a J.D. and a Ph.D. in Anthropology from Columbia University.

Catherine Glenn Foster is President and CEO of Americans United for Life, as well as a Senior Fellow in Legal Policy at the Charlotte Lozier Institute and a Fellow with the James Wilson Institute on Natural Rights and the American Founding. Previously, she spent seven years as litigation counsel with the Alliance Defending Freedom. She then founded and managed a law practice and led Euthanasia Prevention Coalition USA as Executive Director. Ms. Foster earned her B.A. from Barry College, a Master's degree in French from the University of South Florida, and a J.D. from Georgetown University Law Center.

Stephanie Loraine Piñeiro is Co-Executive Director of the Florida Access Network and abortion funds dedicated to challenging abortion stigma and dismantling barriers to abortion in Florida through financial and logistical support. She received her B.A. from the University of North Florida and a Masters of Social Work from the University of Central Florida.

We welcome all our distinguished Witnesses and we thank them for participating today. I will begin by swearing in our Witnesses. I ask that our Witnesses in person, please rise and raise your right hand. I ask that our remote witnesses please turn on their audio and make sure I can see your face and your raised right hand while I administer the oath.

Do you swear or affirm under penalty of perjury that the testimony you are about to give is true and correct to the best of your knowledge, information, and belief so help you God?

Let the record show that the Witnesses have answered in the affirmative. Thank you and be seated.

Please note that each of your written statements will be entered into the record in its entirety. Accordingly, I ask that you summarize your testimony in five minutes. To help you stay within that time, there is a timing light on your table. When the light switches from green to yellow, you have one minute to conclude your testimony. When the light turns red, it signals your five minutes have expired.

For our Witnesses appearing virtually, there is a timer on your screen to help you keep track of time.

Dr. Moayedi, you may begin.

STATEMENT OF GHAZALEH MOAYEDI

Dr. MOAYEDI. Good morning, Chair Nadler, Ranking Member Jordan and distinguished Members of the Committee. My name is Dr. Ghazaleh Moayedi and I use she/her pronouns. I am a Board-Certified OB/GYN, the child of Iranian immigrants, a mom, a Texan, and a proud abortion provider. I serve on the Board of Physicians for Reproductive Health and the Texas Equal Access Fund.

For over 60 days abortion care has been nearly inaccessible in my home State of Texas due to Senate Bill 8. Texans have been waiting for the courts, for Congress, for anyone to intervene and halt this unconstitutional abortion ban. I am here today because we are still waiting.

As dangerous and as cruel as this law is, access in life-saving abortion care has always been a challenge in Texas even before SB 8. Last month, when I testified to the House Oversight Committee on this very issue, I asked the Committee to spend a few minutes thinking about what it is like to be a person needing abortion care in Texas or in this country, to consider Marie, a 35-year-old, American citizen, Eighteen weeks pregnant, working a minimum wage job, and living in Dallas, Texas and seeking abortion care in August, prior to SB 8 even being enacted. She, like most people who have abortions, is already a parent and is resolute in her decision to end her pregnancy. Although Marie is confident and informed about her decision simply because she lives in Texas, Marie is forced to endure multiple harmful restrictions when accessing abortion care. Marie is forced to seek out this care at only one of two specialty clinics in Dallas, not from her regular healthcare provider because Texas has a law that requires abortion care after 16 weeks to be provided at an ASC, an ambulatory surgical center, a requirement that has been proven to be medically unnecessary and has nothing to improve the quality or safety of care.

If Marie is able to make her appointment at one of our two ASCs in Dallas, she cannot have her abortion on the day of her appointment. Marie is forced, by Texas law, to make an appointment with a physician in advance of her procedure. As her physician, I am then compelled by the State to force Marie into a medically unnecessary ultrasound. I am compelled by the State to force Marie to

look at and listen to the ultrasound. I am compelled by the State to force Marie to hear a description of the ultrasound. I am compelled by the State to force Marie to receive medically inaccurate, State-mandated scripts. After all this, I am still compelled by the State to force Marie to wait at least 24 hours to receive her desired healthcare.

Now, if Marie were 16 instead of 35, her abortion care would be even further delayed by the need for parental consent or judicial bypass. If Marie were undocumented and living in El Paso instead of Dallas, she would be completely denied access to abortion because even before SB 8 a lack of abortion providers and the internal border checkpoints within Texas and New Mexico prevent Marie from accessing the next closest clinic.

Now, that the Committee has heard how bad it was in Texas even before SB 8 I want to bring our story of Marie to today, right now. Today, Marie cannot get her abortion in Dallas and because of the influx of Texas patients, the next closest clinic in Oklahoma City where I also provide care has a week's long waiting list for an appointment. I should not be forced to travel hours and hours away from my home to care for patients or my neighbors who traveled hours and hours to see me. By the time Marie is able to schedule an appointment in Oklahoma she will be 22 weeks pregnant and unable to get her care because of Oklahoma's medically unnecessary abortion restrictions.

So, now we are moving in concentric circles further and further away from her home, further and further away from hope. An abortion ban in Texas creates a ripple effect of injustice impacting all of us. The influx of Texas patients is straining our neighboring States, pushing Oklahomans to need abortion care out of their communities to other States, like Arkansas and Kansas. This is what SB 8 intends to do, deny people both in and out of Texas the ability to have abortions.

Today abortion care is almost completely stopped in our State and the health and safety of all pregnant people in Texas is in jeopardy. We know chronic conditions can worsen in pregnancy, but not worsen enough to warrant an exception under this law.

OB/GYNs and other prenatal healthcare providers are confused about how to comply and care for their patients. Right now, today, physicians and hospitals in Texas are delaying life-saving care for critically ill pregnant people because their pregnancy still have fetal cardiac activity. As a physician, I know firsthand that abortion saves lives. For the thousands of people I have cared for, abortion is a blessing. Abortion is an act of love. Abortion is freedom.

I want to end by imploring this Committee to help our communities right now. We need Federal protection of abortion care and most of care, we need you to not forget about us, the people of Texas and in other heavily restricted States and our families and our communities.

Thank you for hearing me today and holding this important hearing.

[The statement of Dr. Moayedi follows:]

Testimony of Dr. Ghazaleh Moayedi, DO
House of Representatives Committee on the Judiciary
The Texas Abortion Ban and its Devastating Impact on Communities and Families

Good morning Chairman Nadler, Ranking Member Jordan, and distinguished Members of the Committee. My name is Dr. Ghazaleh Moayedi and I use she/her pronouns. I am a Board Certified OB/GYN, the child of Iranian immigrants, a mom, a Texan, and a proud abortion provider. I am a full-spectrum OB/GYN, which means that in addition to pregnancy and birth care, I provide abortion care in both Texas and Oklahoma. I am a Board Member with both Physicians for Reproductive Health and the Texas Equal Access Fund.

For over sixty days—since September 1—abortion has been nearly inaccessible in my home state of Texas due to Senate Bill 8 (S.B.8). Texans have been waiting for the courts to intervene to halt this unconstitutional abortion ban and we are still waiting.

As hateful and cruel as this law is, even before S.B.8 went into effect, accessing abortion care looked very different in our country depending on where you live. I'm a licensed physician who has practiced in Hawai'i, Texas, and Oklahoma providing expert abortion care. Abortion is exceedingly safe. This has been established through decades of rigorous clinical research, time and time again. And although I am the same physician, with the same expert skills and training in all of these places, by complying with the countless, cruel, and medically unnecessary abortion restrictions in Texas and Oklahoma, I am compelled by these states to provide substandard care for my community members compared to the people I have cared for in Hawai'i.

I want the Committee to spend a few minutes thinking about what it is like to be a person needing abortion care in this country. Imagine Marie: a thirty-five-year old, American citizen, eighteen weeks pregnant, working a minimum wage job, and living in Dallas, Texas. Marie is seeking abortion care in August, just prior to S.B.8 being enacted. She, like most people who have abortions, is already a parent and is resolute in her decision to end her pregnancy.

Although Marie is confident and informed about her decision to end her pregnancy, even before the passage of S.B.8, Marie is forced to endure multiple harmful restrictions when accessing abortion care. First, Texas has a law that requires abortion care after sixteen weeks to be provided in an Ambulatory Surgical Center (ASC)—a requirement that has been proven to be medically unnecessary and does nothing to improve the quality or safety of care. In Dallas, Marie must find an ASC for her care—and for the nearly seven-million-person metroplex of Dallas-Fort Worth, there are three, only two of which are in Dallas. By contrast, Hawai'i has no law restricting where people can access this essential healthcare.

If Marie is able to make an appointment at one of our two ASCs in Dallas, she cannot have her abortion on the day of her appointment. By Texas law, she must make an appointment to see me, a physician, in advance of her procedure. As her physician, I am then compelled by the state to force Marie into a medically unnecessary ultrasound. I'm compelled by the state to force Marie to hear a description of the ultrasound. I'm compelled by the state to force Marie to hear medically inaccurate, state-mandated scripts. After all of this, Marie still cannot have her desired

abortion. She must return at least twenty-four hours later, because I'm compelled by Texas to force her to wait, even though it is medically unnecessary and goes against my better judgment as a physician. And, to make matters worse, if one of my colleagues is providing care the next day, and not me, Marie must wait even longer. Because Texas forces people to have abortion care from the same physician that gave them their ultrasound. In Honolulu, Marie could call my office for an appointment in the morning and be heading home in the afternoon. It could be this effortless for people to get the health care they need, but Texas, Oklahoma, and other states across the country, intentionally create obstacles that punish people seeking abortion care.

To add insult to injury, if Marie were able to jump through all these hurdles in Dallas, she still must pay for this procedure out of her own pocket. This is because Medicaid and private insurance do not cover abortion in Texas. In Hawai'i—unless Marie is a member of the military or a federal employee—her private health insurance or her Medicaid would cover her costs. If she were living in Hawai'i, Marie would not have to forgo food, or rent, or childcare to access her constitutional right to an abortion. In Texas, Marie will.

And this is just one, small example of how even before S.B.8 went into effect, the same physician, with the same skills and expertise is forced to dehumanize the patients she serves because of where they live. It is outrageous that as a physician, I am forced to deny timely and high-quality care to the very community I have taken an oath to serve, simply because pregnant people in Texas do not have equal protection under the law. High-quality, patient-centered healthcare should be easily accessible without unnecessary delay. In fact, the National Academies of Science, Engineering, and Medicine found that the greatest threat to the quality of abortion care are unnecessary restrictions like the ones I just described.

Now if Marie were sixteen, instead of thirty-five, her abortion care would be even further delayed by the need for parental consent or judicial bypass. If Marie were undocumented and living in El Paso, instead of Dallas, she would be completely denied access to abortion, even before S.B.8, because of the lack of providers and the internal border checkpoints within Texas and New Mexico that would prevent her from accessing the next, closest clinic.

Now that the Committee has heard how bad it was in Texas, even before S.B.8, I want to bring our story of Marie to today, right now.

Today, if Marie were eighteen weeks pregnant, she cannot get an abortion in Dallas. The next closest clinic is in Oklahoma City – where I am currently providing care – which, because of the massive influx of Texas patients, had a one month waiting list for an appointment before S.B.8 even went into effect. I should not be forced to travel hours and hours away from my home to care for patients, my neighbors, who traveled hours and hours to see me. There is something incredibly wrong with this picture, and the impact does not end with the folks traveling to receive and provide care. An abortion ban in Texas impacts all of us. People in Oklahoma are already experiencing the ripple effect of this injustice. The influx of Texas patients is straining our neighboring states, pushing people in Oklahoma who need abortion care out of their communities to other states like Arkansas and Kansas. Now for Marie, by the time she is able to schedule her appointment with this increased wait time, she would be twenty-two weeks pregnant and unable to get care in Oklahoma, because of their state law. So now we're moving in

concentric circles, further and further away from home, and further and further away from hope. This is what S.B. 8 is intended to do – deny people, both in and out of Texas, the ability to have abortions.

Today, abortion care has almost completely stopped in our state. Only a fraction of patients right now are able to get the care they need in Texas—the largest decline in abortion care in our state ever recorded. Clinics are working tirelessly to care for everyone they can in Texas within the limits of the law. And they are coordinating non-stop with abortion funds on getting everyone else out of state for care. And it's not just the clinics in Texas doing this coordinating—providers, funds, and patients are feeling the ripple effects of this law across the nation as care is strained and increasingly more difficult to access. And unfortunately, we know not everyone will be able to get care in another state. The impact of this law is devastating. It is terrifying. Not only for people with undesired pregnancies seeking abortion care, but also for people with highly desired pregnancies who have pregnancy complications.

The consequences of this hateful and cruel law are far reaching. OB/GYNs and other prenatal health care providers are confused. My colleagues are asking if they are still allowed to treat ectopic pregnancy. Right now, today, physicians and hospitals in Texas are delaying life-saving care for critically ill pregnant people because their pregnancies still have fetal cardiac activity. We are worried about all of the possible chronic conditions that can worsen in pregnancy, but not worsen enough to warrant an exception under this law. S.B.8 has not only caused a near total abortion ban in Texas, it has also made it extremely dangerous to be a pregnant person in our state, where maternal morbidity and mortality is already unconscionably high, especially for Black women and pregnant people of color. Texans deserves better.

As a physician, I know first-hand that abortion saves lives. For the thousands of people I've cared for, abortion is a blessing. Abortion is love. Abortion is freedom. As a mom and an OB/GYN, I know abortion care is part of supporting thriving families and communities. Access to timely, compassionate, and culturally relevant abortion care is a critical public health measure. All Texans have the human right to have children, the human right to parent their children in safe communities, and the human right to abortion care.

It is critical for this Committee to understand the dire consequences facing all of our communities right now. We need federal protection of abortion. We need laws that recognize the dignity and autonomy of people accessing this care. We need policies that elevate science and evidence, not politics. The Women's Health Protection Act is an important and critical step, but it is not enough. We need legislation like the EACH Act, the Momnibus Bill, the HEAL for Immigrant Families Act– measures that will protect pregnant and birthing people in all of their decisions so that they can live their best and healthiest lives. But most of all, we need you to not forget us, the people of Texas and other heavily restricted states, who are trying our best to care for ourselves, our families, and our communities amidst efforts to completely control our bodies and lives.

Thank you for having me here today and for holding this important hearing.

Chair NADLER. Thank you for your testimony. Professor Bridges, you are recognized.

STATEMENT OF KHIARA M. BRIDGES

Dr. BRIDGES. Chair Nadler, Ranking Member Jordan, and Members of the House Committee on the Judiciary, thank you for the opportunity to testify before you today. My name is Khiara Bridges, and I am a Professor of Law at the University of California, Berkeley, School of Law, where I teach Criminal Law, Family Law, and Reproductive Rights and Justice. I also serve as the Faculty Director of the Berkeley Center on Reproductive Rights and Justice.

I am here today to explain how abortion restrictions and bans, like Texas Senate Bill 8, disproportionately impact pregnant people of color—especially Black women.

For decades, the Supreme Court has reaffirmed the central holding of *Roe* v. *Wade*. The court has affirmed that a person has a right "to choose to have an abortion before viability and to obtain it without undue interference from the State." The Court in *Planned Parenthood* v. *Casey* made clear that a "woman's right to terminate her pregnancy before viability is the most central principle of *Roe*. It is a rule of law and a component of liberty we cannot renounce." Texas Senate Bill 8, SB 8, which bans abortion after six weeks of pregnancy, violates this central principle of *Roe*. The law constitutes a near-total ban on abortion banning abortion far before viability and before many people even know they are pregnant. Consequently, SB 8 is unconstitutional.

Nevertheless, SB 8 is currently in effect and has been harming Texans in need of abortion care for over two months. This is solely because the law leaves enforcement of its prohibition on abortion to private citizens instead of State actors, a feature of the law that its architects hoped would permit the law to evade judicial review. The United States Supreme Court cited these "complex and novel antecedent procedural questions" as a reason for not enjoining the law. It is important to reiterate that the sole reason that SB 8 contains these "procedural questions" is that its authors wanted to give receptive Federal courts the opportunity to leave the law in place.

The Fifth Circuit and the Supreme Court took advantage of the opportunity that SB 8's authors gave them. The Fifth Circuit and the Supreme Court left the law in place. In the words of Justice Sotomayor "The State's gambit has worked." The law is in effect. For two months abortion providers in Texas have been unable to provide care to scores of patients who desperately need it.

Because Texans seeking to exercise their constitutional rights to abortion must now travel outside of the State to do so, the burdens imposed by SB 8 are tremendous. The greatest harms have fallen and will continue to fall on the most marginalized people in Texas. Indeed, for the poorest people in Texas, these burdens are insurmountable.

Crucially, because there is a close relationship between socio-economic status and race, Black people disproportionately living in poverty burdens to poor people constitute burdens to Black people. The result is that disproportionate numbers of Black people will be among those who are coerced to continue pregnancies and have

children against their will to seek unsafe methods of abortion or to risk exposure to criminal prosecution for attempting to self-manage abortion.

Further, Black people receive abortion care at higher rates than their counterparts of other races. This is true in large part because Black people experience unintended pregnancies at higher rates than their counterparts of other races. Because Black people rely on abortion care more frequently than their non-Black counterparts, various abortions like SB 8 inflicts greater harms on Black people than other races. Essentially, abortion restrictions do not have race-neutral effects.

Feminists of color have long recognized the importance of ensuring that Black women and other Black people who can become pregnant are able to decide whether or not they will become parents. They have understood that there are forces that would coerce Black people into parenthood like the forces that wrongly assert that abortion is Black genocide. They have also understood that there are forces that would deny Black people parenthood like the forces that subjected tens of thousands of Black women to forced sterilizations from the 1950–1980s and beyond.

Because feminists of color have realized that controlling Black people's reproduction has been a tool of racial oppression, they have identified Black people's ability to control their own reproduction as a tool for racial justice. Because of the ability to terminate a pregnancy enables Black people to control their reproduction, Feminists of color, like myself consider abortion access to be essential to racial justice. Thus, SB 8 and other regulations that make abortion inaccessible are tools of racial subordination. Thank you.

[The statement of Dr. Bridges follows:]

TESTIMONY OF KHIARA M. BRIDGES

PROFESSOR OF LAW, UC BERKELEY SCHOOL OF LAW

BEFORE THE HOUSE COMMITTEE ON THE JUDICIARY

"THE TEXAS ABORTION BAN AND ITS DEVASTATING IMPACT ON COMMUNITIES AND FAMILIES"
NOVEMBER 4, 2021

Chairman Nadler, Ranking Member Jordan, and Members of the House Committee on the Judiciary, thank you for the opportunity to testify before you today. My name is Khiara M. Bridges, and I am a Professor of Law at the University of California, Berkeley, School of Law, where I teach Criminal Law, Family Law, and Reproductive Rights and Justice. I also serve as the Faculty Director of the Berkeley Center on Reproductive Rights and Justice. I am here today to explain how abortion restrictions and bans, like Texas Senate Bill 8, disproportionately impact pregnant people of color—especially black women.

For decades, the Supreme Court has reaffirmed the central holding of *Roe v. Wade*: a person has a right "to choose to have an abortion before viability and to obtain it without undue interference from the State."[1] The Court in *Planned Parenthood v. Casey* made clear that a "woman's right to terminate her pregnancy before viability is the most central principle of *Roe*. It is a rule of law and a component of liberty we cannot renounce."[2] Texas Senate Bill 8 (SB8), which bans abortion after six weeks of pregnancy, violates this central principle of *Roe*. The law constitutes a near-total ban on abortion—banning abortion far before viability and before many people even know they are pregnant. Consequently, SB8 is unconstitutional.

Nevertheless, SB8 is in effect as of the filing of this testimony, and it has been harming Texans in need of abortion care for over two months. This is solely because the law leaves enforcement of its prohibition on abortion to private citizens instead of state actors—a feature of the law that its architects hoped would permit the law to evade judicial review. The United States Supreme Court cited these "complex and novel antecedent procedural questions" as a reason for not enjoining the law.[3] It is

[1] *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992).

[2] *Id.* at 871.

[3] *Whole Woman's Health v. Jackson*, No. 21A24, 2021 WL 3910722 (U.S. Sept. 1, 2021) (mem.).

important to reiterate that SB8 contains these "procedural questions" solely because its authors wanted to give receptive federal courts the opportunity to leave the law in place. In essence, "the State's gambit has worked."[4] Abortion providers in Texas have been unable to provide care to scores of patients who desperately need it.[5]

The federal courts have allowed Texas to infringe the constitutional rights of the people within its borders. In practice, some people seeking to control their reproductive lives have been able to surmount the hurdles of this unconstitutional abortion ban by traveling out of state.[6] But the greatest harms have fallen, and will continue to fall, on the most marginalized people in Texas. For them, SB8's burdens—including increased costs associated with the procedure itself, travel expenses, the cost of childcare services when they are away from home, wages they will have to forfeit when taking time off of work, and the cost of accommodations if the location to which they have to travel for abortion care is so far away from home that they have to stay overnight—are insurmountable.

The lengths to which Texans are going to access abortion are not new. While the constitutional right to abortion remains intact in theory, medically unnecessary abortion regulations have been closing clinics and imposing burdens on patients for decades. Many states have managed to erode access to abortion to the point of near extinction. And just as in Texas, the burdens fall most heavily on those without the means to overcome them—poor people.

Crucially, because there is a close relationship between socioeconomic status and race—with black people disproportionately living in poverty—burdens to *poor* people constitute burdens to *black* people.[7] The result is that disproportionate numbers of black people will be among those who are coerced to continue pregnancies and have children against their will, to seek unsafe methods of abortion, or to risk exposure to criminal prosecution for attempting to self-manage abortion. The reproductive justice framework asserts that all people deserve the right to control their bodies, including the right to determine if and when they will have a child. While the decision whether to carry a pregnancy to term is impacted by access to economic, social, and political power, individuals must be able to make the decision for

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[4] *United States v. Texas*, slip op. at 6, No. 21A85 (U.S. Oct. 22, 2021) (Sotomayor, J., dissenting).

[5] *See* Kari White et al., *Initial Impacts of Texas' Senate Bill 8 on Abortions in Texas and at Out-of-State Facilities*, TEX. POLICY EVALUATION PROJECT 1, 1 (Oct. 2021), http://sites.utexas.edu/txpep/files/2021/11/TxPEP-brief-SB8-inital-impact.pdf (finding that the number of abortions in Texas fell by half following the implementation of SB8); *see also* Claire Cain Miller, Quoctrung Bui, & Margot Sanger-Katz, *Abortions Fell by Half in Month After New Texas Law*, THE N.Y. TIMES (Oct. 29, 2021), https://www.nytimes.com/interactive/2021/10/29/upshot/texas-abortion-data.html.

[6] *See* Barbara Hoberock, *Oklahoma City abortion clinic sees caseload double after Texas law takes effect*, TULSA WORLD (Sept. 26, 2021), https://tulsaworld.com/news/state-and-regional/oklahoma-city-abortion-clinic-sees-caseload-double-after-texas-law-takes-effect/article_f967e386-1d4c-11ec-a0d7-3b7232634b6b.html; *see also* Brief for Planned Parenthood of Greater Texas Surgical Health Services et al. as Amici Curiae Supporting Petitioners, *United States* v. *Texas*, No. 21-588 (U.S. Oct. 2021).

[7] *See* Melissa Murray, *Race-ing Roe: Reproductive Justice, Racial Justice, and the Battle for Roe v. Wade*, 134 HARV. L. REV. 2025, 2093 (2021) ("[B]ecause race and socioeconomic status are often related—particularly in those regions of the country where abortion restrictions are more extensive—the burden on poor women will also result in a burden on women of color, rendering abortion inaccessible to these groups.").

themselves. Denying black people the ability to determine the reproductive trajectory of their lives, which abortion bans like SB8 and other abortion restrictions accomplish, is a form of racial injustice that continues a long history of reproductive oppression of people of color.

I. CONSTITUTIONAL PROTECTIONS FOR ABORTION RIGHTS AND THE DEVASTATING IMPACT OF ABORTION BANS AND RESTRICTIONS

The landmark decision *Roe v. Wade* guarantees each individual the right to make personal decisions about family, relationships, and bodily autonomy.[8] Since that decision, the Supreme Court has repeatedly reaffirmed *Roe*'s central holding, including in *Planned Parenthood v. Casey*, where the Supreme Court explained that "the ability of women to participate equally in the economic and social life of the nation has been facilitated by their ability to control their reproductive lives."[9] Over the decades since the Court first held that the Constitution encompasses protection for the right to abortion, most recently in *June Medical Services v. Russo*, it has also recognized that the right is meaningless if restrictions are allowed to dismantle actual access to abortion services.[10]

But despite the clear recognition of a constitutional right to abortion, anti-abortion lawmakers and advocates have engaged in a decades-long strategy to undermine this right, with the stated goal of overturning *Roe v. Wade*.[11] In the forty-seven years since *Roe* was decided, states have enacted 1,336 abortion restrictions[12] and are showing no sign of slowing down. Nearly half of those restrictions were enacted in the last ten years. Further, state legislatures that are hostile to abortion rights have grown increasingly brazen. In the last two years alone, Georgia, Idaho, Iowa, Kentucky, Louisiana, Mississippi, Oklahoma, South Carolina, and Texas have enacted 6-week bans—i.e., laws that ban abortion about two weeks after a missed regular period and before many people even know they are pregnant; Missouri enacted an 8-week ban; and Alabama banned abortion from the moment of conception.[13] Texas SB8, a law that uses a private enforcement mechanism to enforce

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[8] *Roe v. Wade*, 410 U.S. 113, 155, 153 (1973).

[9] *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 835 (1992).

[10] *June Medical Services v. Russo*, 591 U.S. __ (2020).

[11] *See, e.g.*, AMS. UNITED FOR LIFE, DEFENDING LIFE 2021 (2021), https://aul.org/wp-content/uploads/2021/02/Defending-Life-2021.pdf.

[12] *See U.S. states have enacted 1,336 abortion restrictions since Roe v. Wade was decided in 1973*, GUTTMACHER INST. (Oct. 1, 2021), https://www.guttmacher.org/infographic/2021/us-states-have-enacted-1336-abortion-restrictions-roe-v-wade-was-decided-1973.

[13] *Robinson v. Marshall*, 415 F. Supp. 3d 1053 (M.D. Ala. 2019) (striking down near-total abortion ban); *Women of Color Reprod. Justice Collective v. Kemp*, 472 F. Supp. 3d 1297 (N.D. Ga. 2020), *appeal filed*, No. 20-13024 (11th Cir. Aug. 11, 2020); *Planned Parenthood of the Heartland v. Reynolds*, No. EQCE83074, 2019 WL 312072 (Iowa Dist. Ct. Polk Cty. Jan. 22, 2019); *EMW Women's Surgical Ctr., P.S.C. v. Beshear*, No. 3:19-CV-178-DJH, 2019 WL 1233575 (W.D. Ky. Mar. 15, 2019) (temporary restraining order); *Reproductive Health Services of Planned Parenthood of the St. Louis Region, Inc. et al. v. Parson*, No. 2:19-cv-4155-HFS (W.D. Mo. Aug. 27, 2019); *Preterm-Cleveland v. Yost*, 394 F. Supp. 3d 796, 804 (S.D. Ohio 2019) (preliminary injunction); *Memphis Ctr. For Reprod. Health v. Slatery*, No. 3:20-CV-00501, 14 2020 WL 4274198 (M.D. Tenn. July 24, 2020) (granting preliminary injunction), *appeal filed*, No. 20-5969 (6th Cir. Aug. 24, 2020); *Jackson Women's*

a ban on abortion at six weeks of pregnancy, is without doubt the most draconian abortion law that has been allowed to stand since the *Roe* decision was handed down. Other states are already gearing up to pass copycat laws.[14]

Restrictions and bans like SB8 have undoubtedly been a success for those who seek to use legislation to impede access to the constitutional right to abortion. These laws, whether they are targeted regulations of abortion providers (TRAP laws), gestational bans, or medically unnecessary restrictions disguised as "good medicine," have had the dual devastating effect of closing down abortion clinics *and* preventing patients from accessing care at the clinics that remain. In order to comply with the multiple hurdles placed in their path, patients are forced to travel increasingly long distances, forfeit wages, and risk their jobs in order to access their constitutionally protected right to abortion.

A. Texas Senate Bill 8

Texas Senate Bill 8 (SB8) bans abortion care after approximately six weeks of pregnancy—before many people know they are pregnant—and incentivizes private individuals to seek monetary gain by suing anyone who provides an abortion or assists a pregnant person in obtaining one after the law's limit. SB8 has the purpose—and has had the documented effect—of eliminating most abortions in Texas while making it exceedingly difficult to challenge the law in court.[15]

Pre-viability abortion bans have been universally blocked by federal courts when challenged, but SB8 was specifically designed to be difficult to block before it took effect. By shifting enforcement from state officials to private individuals, Texas attempted to evade legal accountability and prevent the federal courts from enjoining this unconstitutional ban before it took effect—in essence, "box[ing] out the judiciary."[16]

To quote Justice Sotomayor: SB8 is "a breathtaking act of defiance – of the Constitution, of [the Supreme] Court's precedents, and of the rights of women seeking abortion throughout Texas."[17]

Health Org. v. Dobbs, 951 F.3d 246 (5th Cir. 2020) (affirming preliminary injunction of Texas's 6-week ban); H.B. 366, 66th Leg. Reg. Sess. (Idaho 2021) https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2021/legislation/H0366.pdf; S.B. 184, 2019 Reg. Sess. (La. 2019) http://www.legis.la.gov/legis/ViewDocument.aspx?d=1140119 (enacted "heartbeat" ban that would have become effective had the Fifth Circuit upheld Mississippi's ban); H.B. 2441, 58th Leg. Reg. Sess. (Okla. 2021) http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20ENR/hB/HB2441%20ENR.PDF; S.B. 1, 124th Gen. Assemb. (S.C. 2021) https://www.scstatehouse.gov/sess124_2021-2022/bills/1.htm.

[14] Caroline Kitchener, *Lawmakers are racing to mimic the Texas abortion law in their own states. They say the bills will fly through.*, THE LILY (Oct. 19, 2021), https://www.thelily.com/lawmakers-are-racing-to-mimic-the-texas-abortion-law-in-their-own-states-they-say-the-bills-will-fly-through/.

[15] Claire Cain Miller, Quoctrung Bui, & Margot Sanger-Katz, *Abortions Fell by Half in Month After New Texas Law*, THE N.Y. TIMES (Oct. 29, 2021), https://www.nytimes.com/interactive/2021/10/29/upshot/texas-abortion-data.html.

[16] Reply Brief of Intervenors at 3-4, *United States v. Texas*, No. 21-50949 (5th Cir. Oct. 14, 2021).

[17] *Whole Woman's Health v. Jackson*, slip op. at 3, No. 21A24 (U.S. Sept. 1, 2021) (Sotomayor, J., dissenting).

"Breathtaking" describes not only Texas's defiance and the Kafkaesque features of SB8 designed to shield it from the judiciary, but also the impact on people in Texas. Pregnant people are "devastated" and "panicked."[18] Some people with resources have fled to other states, an exodus that has had "stunning" and "crushing" impacts on the clinics in those states; moreover, this exodus has frustrated the ability of the residents of those neighboring states to make appointments to obtain abortion services.[19] Many other Texans are unable to attain abortion care out of state because of finances, dangerous situations, immigration status, or other obstacles.[20] While SB8 and other abortion regulations would appear to apply equally across the board, the people who find themselves without recourse in the shadow of abortion restrictions are people of color, native people, people with disabilities, young people, LGBTQ+ people, and others whose access to abortion is additionally frustrated by structural inequities in access to health care.

On November 1, 2021, the Supreme Court heard oral arguments in two cases challenging Texas SB8: a lawsuit filed by a coalition of abortion providers and advocates represented by the Center for Reproductive Rights, Planned Parenthood Federation of America, the Lawyering Project, the ACLU, and the ACLU of Texas, and a second lawsuit filed by the U.S. Department of Justice (DOJ). The cases respectively address the threshold issue of whether federal courts have the power to preemptively block blatantly unconstitutional laws like S.B. 8 and whether the DOJ can seek injunctive relief against Texas judges, clerks, and other state officials. The Court deferred ruling on the DOJ's request to block the law until after oral argument on November 1.

Dissenting from the Court's decision not to block SB8 immediately, Justice Sotomayor vividly wrote[21]:

> I cannot capture the totality of this harm in these pages . . . . [Texas] has so thoroughly chilled the exercise of the right recognized in *Roe* as to nearly suspend it within its borders and strain access to it in other States. The State's gambit has worked. The impact is catastrophic. These ruinous effects were foreseeable and intentional.

If the Supreme Court holds that neither the coalition of abortion providers nor the Department of Justice can challenge SB8, and that federal courts are powerless to block laws like SB8, there most certainly will be a proliferation of legislation passed in other states that prohibit the exercise of disfavored federal constitutional rights,

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[18] *United States v. Texas*, No. 1:21-CV-796-RP, 2021 WL 4593319 at *40 (W.D. Tex. Oct. 22, 2021).

[19] *Id.* at *43-45.

[20] *Id.* at *42.

[21] *United States v. Texas*, slip op. at 6, No. 21A85 (U.S. Oct. 22, 2021) (Sotomayor, J., dissenting).

including outright bans on access to abortion, limitations on free speech, and restrictions on the right to marry.

II. BLACK PEOPLE ARE SYSTEMATICALLY DENIED THEIR CONSTITUTIONAL RIGHT TO ACCESS ABORTION

A. Black people make up a disproportionate number of those who obtain abortions in the U.S.

In 2018, the rate of abortion was 21.2 per thousand black women and 6.3 per thousand white women, making black women more than three times as likely to receive abortion services than their white counterparts.[22] Consequently, any law that makes it more difficult for people to access abortion makes it more difficult for black people to access abortion.

B. Intersecting and systemic conditions of inequality, which disproportionately affect black people, compound the effects of abortion restrictions and bans

Women, people of color, low-income people, trans and nonbinary people, LGBTQ+ people, immigrants, native people, and people with disabilities all face unique challenges when seeking affirming, affordable, and high-quality healthcare. These various challenges place abortion and other reproductive care services out of reach for many. These inequities compound the harms of abortion barriers and restrictions, creating circumstances under which many people of color are systematically precluded from accessing their constitutional right to abortion.[23]

1. Black people disproportionately bear the burdens of poverty in the United States

While the poverty rate among white people in 2019 was 7.3 percent, the rate among black people was 18.8 percent.[24] Thus, black people are more than twice as likely as their white counterparts to be impoverished. The costs of accessing abortion care are greatly exacerbated by abortion bans and other restrictions, the navigation of which necessitates resources to cover childcare costs, missed wages, transportation costs, and risks to employment that come with taking time off of work for those who do not have access to paid or unpaid leave. For the impoverished, these costs are often

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[22] *Abortion Surveillance – United States, 2018*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 27, 2020), https://www.cdc.gov/mmwr/volumes/69/ss/ss6907a1.htm#T5_down.

[23] *See, e.g.*, Murray at 2090–91 ("As reproductive justice advocates make clear, for many people of color, the decision to terminate a pregnancy is shot through with concerns about economic and financial insecurity, limited employment options, diminution of educational opportunities and lack of access to health care and affordable quality childcare.").

[24] John Creamer, *Inequalities Persist Despite Decline in Poverty For All Major Race and Hispanic Origin Groups*, U.S. CENSUS BUREAU (Sept. 15, 2020), https://www.census.gov/library/stories/2020/09/poverty-rates-for-blacks-and-hispanics-reached-historic-lows-in-2019.html.

impossible to overcome, putting abortion care out of reach for low-income people who live in states with onerous abortion restrictions.

2. Black people are more likely than other racial groups to encounter difficulties accessing safe and effective contraception

Most people who have abortions generally do so to terminate an unintended pregnancy.[25] Notably, researchers have documented that black people experience unintended pregnancies at higher rates than white people.[26] Black people's higher rate of unintended pregnancy is due, in significant part, to barriers to their obtaining safe, effective contraception.[27] These barriers include the scarcity of geographically accessible reproductive healthcare, the financial inaccessibility of more reliable but "usually more expensive" prescription contraceptives, and a basic unavailability of general medical care.[28] Further, without health insurance, accessing effective contraception is much more difficult, thereby increasing the likelihood of an unintended pregnancy and the consequent need for abortion care.

3. Black women experience higher rates of intimate partner violence

Because black people have higher rates of poverty, black people who identify as women experience intimate partner violence at higher rates than women of other races.[29] Specifically, more than 40% of black women experience physical violence by an intimate partner, compared with 31.5% of all women.[30] Further, black women are more likely than women of other races to be victims of rape during their lifetimes.[31] Black women also experience reproductive coercion—where "partners actively try to impregnate their partner against their wishes, interfere with contraceptive use," pressure their partner not to use contraception, or interfere with condom use—at higher rates than white women.[32] The higher rate of intimate partner violence, sexual assault, and reproductive coercion among black women—coupled with their lack of access to safe and effective contraception—contributes to higher rates of unintended pregnancies, and therefore higher rates of abortion, among black people.

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[25] Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 110, 110 (2005).

[26] Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 GUTTMACHER POL'Y REV. 2, 3 (2008).

[27] *Id.* at 2–4.

[28] *Id.* at 4–5.

[29] ASHA DUMONTHIER ET AL., INST. FOR WOMEN'S POL'Y RSCH., THE STATUS OF BLACK WOMEN IN THE UNITED STATES xix (2017).

[30] DUMONTHIER ET AL. at 119.

[31] *Id.* at 120–21.

[32] Charvonne N. Holliday et al., *Racial Differences in Pregnancy Intention, Reproductive Coercion, and Partner Violence Among Family Planning Clients: A Qualitative Exploration*, 28 WOMEN'S HEALTH ISSUES 205, 206 (2018).

4. Black people experience significantly higher rates of maternal mortality and morbidity than white people

Maternal mortality is a tragedy in this country. The 2018 maternal mortality ratio ("MMR") in the U.S.—17.4 deaths per 100,000 live births—is more than double that of most other high-income countries and as much as *nine* times higher than some (such as New Zealand and Norway).[33] And this number was even higher (20.1) in 2019.[34]

The national MMR obscures the fact that not all people in the U.S. are similarly situated when it comes to the likelihood that they will not survive pregnancy, childbirth, or the postpartum period. To be precise, the path to motherhood is significantly deadlier for nonwhite people, specifically black people, than it is for white people.

Black people are more than three times as likely to die from pregnancy-related causes than their white counterparts.[35] This racial disparity in maternal mortality has persisted across generations.[36] Indeed, the gap has widened.[37] Eighty years ago, black people were twice as likely as white people to die on the path to parenthood.[38] Thirty years ago, black people were three times as likely as white people to die.[39] Decades later, those odds are unchanged.[40]

Maternal morbidity is also a tragedy in this nation. "Severe maternal morbidity" refers to cases in which a pregnant or recently postpartum person faces a life-threatening diagnosis or must undergo a life-saving medical procedure—like a hysterectomy, blood transfusion, or mechanical ventilation—to avoid death.[41] For every maternal death in the country, there are close to 100 cases of severe maternal morbidity.[42] As with maternal mortality, there are racial disparities in rates of severe

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[33] Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, COMMONWEALTH FUND (Nov. 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries.

[34] Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2019*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 21, 2021), https://www.cdc.gov/nchs/data/hestat/maternal-mortality-2021/maternal-mortality-2021.htm.

[35] *See Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 25, 2020), https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm (for every 100,000 live births from 2014-2017, 13.4 non-Hispanic white women died of pregnancy-related causes compared to 41.7 non-Hispanic black women).

[36] YALE GLOB. HEALTH JUST. P'SHIP, WHEN THE STATE FAILS: MATERNAL MORTALITY AND RACIAL DISPARITY IN GEORGIA 16 (2018).

[37] Elizabeth Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 CLINICAL OBSTETRICS & GYNECOLOGY 387, 387 (2018).

[38] YALE GLOB. HEALTH JUST. P'SHIP at 16.

[39] *Id.*

[40] *See Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 25, 2020), https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

[41] Howell at 387.

[42] *Id.*

maternal morbidity. Presently, black people are twice as likely as their white counterparts to suffer severe maternal morbidity.[43]

Thus, while forcing gestation is always cruel, forcing *black* people to gestate is particularly cruel inasmuch as they are significantly more likely than their white counterparts to die or be severely injured during pregnancy, childbirth, or shortly thereafter. Thus, abortion prohibitions like SB8 have the effect of forcing black people to continue pregnancies in a country where people generally—and black people particularly—have poor chances of surviving the event relative to their counterparts in other industrialized nations.

It is important to note that most maternal deaths in the U.S. are preventable.[44] Accordingly, most maternal deaths—and most cases of severe maternal morbidity—should not be understood as an unfortunate but unavoidable consequence of pregnancy and childbirth. Instead, they are the result of a societal failure to guard the health of people who can become pregnant. Thus, the U.S.'s embarrassingly high maternal mortality ratio is a product of the nation's failure to institute policies that will protect the lives of its citizens. There is a callous brutality involved in the choices of state legislatures to enact abortion restrictions and to compel childbirth while also doing nothing to ensure that people will survive the task that they have been coerced to perform.

C. Structural inequities that black people face exacerbate harms of abortion restrictions and contribute to systematic deprivation of black people's constitutional right to abortion

Black people are more likely to live in poverty, experience domestic violence, and lack access to contraception and other basic health care services. These inequities contribute to black people's higher rate of abortion, but also compound the barriers created by abortion restrictions on access to care. Abortion bans and restrictions create a cruel cycle from which black people are less likely to escape than their white counterparts. As a result, these laws have the distinct effect of depriving black people specifically of their constitutional right to abortion.

III. ACCESS TO ABORTION IS ESSENTIAL FOR REPRODUCTIVE JUSTICE

Feminists of color have long recognized the importance of ensuring that black women and other black people who can become pregnant are able to decide whether or not they will become parents. They have understood that there are forces that

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[43] Andreea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010*, 210 AM. J. OBSTETRICS & GYNECOLOGY 435.e1, 435.e6 (2014).

[44] *Pregnancy-related Deaths*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 7, 2019), https://www.cdc.gov/vitalsigns/maternal-deaths/index.html.

would compel black people into parenthood—like the forces that assert that abortion is black genocide.[45] They have also understood that there are forces that would deny black people parenthood—like the forces that subjected tens of thousands of black women to forced sterilizations from the 1950s to the 1980s.[46] Because feminists of color have realized that controlling black people's reproduction has been a tool of racial oppression, they have identified black people's ability to control their *own* reproduction as a tool of racial justice. Because the ability to terminate a pregnancy enables black people to control their reproduction, feminists of color consider abortion access to be essential to racial justice.

Despite recent suggestions[47], the abortion rate among black people is *not* a measure of the success that eugenicists have had among the black population in the U.S. Rather, the abortion rate among black people reflects the power of the forces that foist unintended pregnancy upon them. And, importantly, the abortion rate reflects black people's defiance of those forces. It is a measure of black people's insistence upon carrying a pregnancy to term *only* when they believe that they are ready for their lives to take that course.[48]

To suggest that abortion today is in any way reminiscent of the eugenic practices of yesteryear is to disregard the concept of agency. Eugenics was about coercion; abortion in 2021 is about autonomy. Black people are autonomously choosing a form of healthcare that helps them negotiate the profound constraints that limit the fullness of their lives. That autonomy should be respected.

IV. THE REPRODUCTIVE JUSTICE FRAMEWORK CONTEMPLATES THE CENTRALITY OF ABORTION ACCESS TO RACIAL JUSTICE

In the 1990s, feminists of color created the reproductive justice framework as a response to the almost exclusive attention that the largest and most powerful reproductive rights organizations had given to abortion rights.[49] The black women who were the architects of the reproductive justice framework recognized that abortion rights were essential to racial justice and reproductive freedom. Nevertheless, they felt that affluent white activists' narrow focus on abortion rights led the largest reproductive rights organizations to ignore or deprioritize *other* issues

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[45] *See Our History*, SISTERSONG, TRUST BLACK WOMEN, https://trustblackwomen.org/our-roots (denying that "the oppression of black people should relegate black women to breeding machines with no right to make personal choices about family creation") (last visited Sept. 17, 2021).

[46] Khiara M. Bridges, *White Privilege and White Disadvantage*, 105 VA. L. REV. 449, 470–72 (2019).

[47] *See, e.g.*, *Box v. Planned Parenthood of Indiana & Kentucky*, 139 S. Ct. 1780, 1790 (2019) (Thomas, J., concurring).

[48] *See, e.g.*, *Gonzales v. Carhart*, 550 U.S. 124, 172 (2007) (Ginsburg, J., dissenting) ("[L]egal challenges to undue restrictions on abortion procedures … center on a woman's autonomy to determine her life course ….").

[49] Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. L. & SOC. SCI. 327, 328 (2013); ASIAN CMTYS. FOR REPROD. JUST., A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS AND REPRODUCTIVE JUSTICE 5 (2005), https://forwardtogether.org/wp-content/uploads/2017/12/ACRJ-A-New-Vision.pdf; *see generally* LORETTA J. ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION (2017).

that impacted people's reproductive lives and health.[50] Moreover, the issues that fell under the radar at these organizations tended to be the issues that did not affect affluent white women but rather affected people of color—especially poor people of color.[51] While the creators of the reproductive justice framework recognized that abortion rights were crucial, they also recognized that the legal right to abortion did not represent the full universe of concerns that people faced with respect to their reproductive lives and health.

Importantly, the feminists of color who generated the reproductive justice framework understood that the state's punitive regulation of black people's reproduction—through laws and policies that prevent them from having children, coerce them into having children, or deny them the ability to raise the children that they have—was both a cause and an effect of racial subordination.[52] Thus, the founders of the reproductive justice framework recognized the inextricable relationship between racial oppression and reproductive oppression.

The reproductive justice framework has three prongs—the right *not* to have a child, the right *to* have a child, and the right to parent a child with dignity.[53] Reproductive justice centers all three prongs simultaneously. This is to say: the right *not* to have a child is as important to reproductive justice as the right *to* have a child and the right to parent one's child with dignity. Thus, the right to an abortion, a vital component of the right *not* to have a child, is an essential element of reproductive justice.

It deserves reiterating that feminists of color—black women, specifically—were the architects of the reproductive justice framework. Thus, black women who were committed to racial justice recognized the centrality of abortion rights to their lives and the lives of people like them. Eugenicists and other plotters of genocide have not thrust abortion rights on unwitting black women.[54] Quite the contrary, black women have demanded abortion rights for themselves. They have made these demands because they understand that freedom—for themselves, for their families, for their communities, for their race—is impossible without the ability to control their reproductive capacities.

V. CONCLUSION

This week's arguments before the Supreme Court in two legal challenges to SB8 are set against the backdrop of a perhaps an even-more existential threat to the

[50] Luna & Luker at 333, 335.

[51] *See generally* JAEL SILLIMAN ET AL., UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE (2004).

[52] *See generally* DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY (2d ed. 2017).

[53] Luna & Luker at 328, 338, 340.

[54] *See* Murray at 2028 (characterizing Justice Thomas' concurrence in *Box* as "a misleading and incomplete history in which he associated abortion with eugenics").

right to access abortion. On December 1, the Supreme Court will hear oral arguments in *Dobbs v. Jackson Women's Health Organization*, a challenge to Mississippi's ban on abortion at 15 weeks of pregnancy. The Mississippi case poses a direct challenge to the nearly fifty years of precedent affirming the constitutional right to access abortion. If the Supreme Court allows Mississippi's ban to go into effect, overturning *Roe* in the process, it will be giving states free reign to ban abortion outright. A recent study by the Guttmacher Institute found that if the U.S. Supreme Court were to weaken or overturn *Roe v. Wade*, 26 states would be certain or likely to ban abortion.[55]

But even now, as the constitutional right to abortion remains intact, many states have managed to eliminate access to abortion within their borders. This crisis in access to abortion care in the United States highlights the need for a holistic and intersectional policy response that puts within its range of vision everything from the need for comprehensive paid family and medical leave to laws that tackle the climate crisis and protect the right to vote. This response must address the systemic conditions of inequality that disproportionately affect black people and compound the burdens of abortion restrictions. In this critical moment, we need the reproductive justice framework to inform policymaking so that we can ensure that people have all the necessary economic, social, and political supports to control their bodies, including when and whether to have children. Further, we should trust black women and black people who can become pregnant to do what is best for themselves, their families, and their communities.

[55] *If Roe v. Wade Falls: Travel Distance for People Seeking Abortion*, GUTTMACHER INST., https://states.guttmacher.org/ (last visited Nov. 1, 2021); *What If Roe Fell?*, CTR. FOR REPROD. RIGHTS, https://maps.reproductiverights.org/what-if-roe-fell (last visited Nov. 1, 2021).

STATEMENT OF CATHERINE GLENN FOSTER

Ms. FOSTER. Thank you. Chair Nadler, Ranking Member Jordan, and Members of the Committee, I speak today on behalf of the constitutional and human right to life.

I speak today on behalf of Texas and every community's right to protect our most vulnerable brothers and sisters—White, Black, indigenous, and all people—from extermination.

Let me tell you what the others here on today's panel won't. It's not our many degrees, our Master's degrees, juris doctorates, and medical degrees, that distinguish us. These are all fine accomplishments. None of them, ultimately, matter.

What matters is what we share, our common humanity, and what is at stake is the same, our humanity. I have committed my life to advocating for America's common interest in life and I am committed to opposing the special interests that, tragically, advance killing as a public policy solution.

If you asked most Americans on the street and told them that very serious people were convening hearings to call for more abortions to take place, they'd rightly be speechless.

Yet, that is what is happening here today. We're hearing incredible stories, testimony—marketing, really—for Texas, for America to embrace more abortions.

What's true about abortion is this:

(1) Abortion is the violent tearing apart of helpless children, limb from limb.
(2) Abortion is the wounding and scarring of women and families for the benefit of multibillion-dollar financial interests.
(3) Abortion is a cancer upon America. Abortion must end.

I keep hearing the word devastating today—it's in the name of today's hearing—and pro-abortion activists are repeating it ad nauseam. Devastating.

You know what's devastating? Cancer and natural disasters. Sixty-two million dead babies. That is what is devastating. Sixty-two million dead babies, killed in history's first for-profit corporate sponsored genocide.

It's time for us to move on. As a constitutional attorney, I implore the Supreme Court and every Federal and State lawmaker to act to restore the human right to life.

We're hearing a lot about Texas, but all this got its start because seven men on the U.S. Supreme Court decided to do a terrible thing, to use *Roe* to nullify the democratic consensus against abortion and impose abortion violence upon our people.

The American people have never accepted the injustice of abortion culture. Americans United For Life advocates for the human right to life in culture, law, and policy.

We have been fighting since 1971 from the beginning of the abortion wars for those who govern in our Executive, Congressional, and Judicial branches to simply to their jobs and to protect human life.

There is nothing more alien to America's constitutional way of life than the toleration of abortion and its imposition on women who deserve better choices.

Since Texas Heartbeat Act went into effect earlier this year, there are now literally thousands of human persons alive and thou-

sands of mothers, fathers, families, and communities who will have the joyful chance at building a life together.

A world with fewer abortions is a good world, a future with more Americans is a good future, and families and communities who are offered hope rather than sorrow are powerful Witnesses to the importance of laws that serve justice and the good of all persons.

I am here to remind you of a truth that you already know. A world with fewer abortions is a good world, a better world.

In a few years, the children who are alive today, thanks to Texas Heartbeat Act, will be old enough to understand that you think that it is devastating that they are alive, and their parents can hear you now, by the way.

I celebrate them and I celebrate every heartbeat protected and every life saved. We should be asking ourselves how we can support mothers and fathers from the moment of conception, as Texas does, in every city and in every county through pregnancy resource centers and alternatives, and we should be asking how America can transcend the abortion debate, how America can enact and embrace robust national family policies that support the growth and the thriving of every life, family, and community.

We all have something priceless to contribute. We must first be allowed to live. We can restore America's greatness by choosing to live joyfully together.

We must offer one another our best choices rather than our worst and then we can embrace what comes when abortion is no more—a lifetime of joyful possibilities.

Thank you.

[The statement of Ms. Foster follows:]

CATHERINE GLENN FOSTER, M.A., J.D.

President and CEO, Americans United for Life

Hearing of the House Committee on the Judiciary

"The Texas Abortion Ban and its Devastating Impact on Communities and Families"

November 4, 2021, 10:00 AM

Rayburn House Office Building, Room 2141

Dear Chair Nadler, Ranking Member Jordan, and Members of the Committee:

I am privileged to testify before this Committee on Texas Health & Safety Code § 171.204 (SB 8, or the "Heartbeat Law") and the state of constitutional law as it relates to abortion. I serve as President & CEO of Americans United for Life (AUL), America's original and most active pro-life legal advocacy organization. Founded in 1971, two years before the Supreme Court's decision in *Roe v. Wade*, AUL has dedicated 50 years to advocating for comprehensive legal protections for human life from fertilization to natural death. AUL attorneys are highly regarded experts on the Constitution and legal issues touching on abortion and are often consulted on various bills, amendments, and ongoing litigation across the country. For five decades, Americans United for Life's staff, supporters, and partners have worked tirelessly toward a day when every member of the human family is welcomed in life and protected in law.

Thank you for the opportunity to argue against the narrative that SB 8 and laws like it "devastate" communities and families. The reality is that the abortion rate in this country has been falling dramatically for years, and Texans are stepping up to support their friends and neighbors now that SB 8 is in effect.

I. Congress should not overrule the will of the people of Texas.

Texans enacted SB 8. Too often Members of Congress speak about state-level lawmaking as if it is being imposed upon the voters against their will. Indeed, throughout the legislative process, SB 8 has been supported by people of Texas and their duly elected members of the Texas Legislature. SB 8 had ninety-one bill authors and co-sponsors, including one pro-life Democrat.[1] Both Chambers held in-person hearings and adopted amendments offered.[2] The public weighed in, and lawmakers spent many hours asking questions about the bill. It passed through two committees, was voted favorably through both Chambers, and SB 8 was signed by Governor Abbott on May 19, 2021.[3] Texans sent pro-life majorities to Austin and those lawmakers enacted legislation that serves their constituents.

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[1] For a breakdown of sponsors and cosponsors, *see* SB 8, Texas Legislature Online, https://capitol.texas.gov/billlookup/History.aspx?LegSess=87R&Bill=SB8 (last visited Nov. 2, 2021).
[2] For hearing dates and amendments, *see id.*
[3] *Id.*

Polling data is beginning to bear this out. The "Texas Trends Survey 2021" conducted by researchers at the University of Houston and Texas Southern University in October 2021 found that 55% of Texans supported SB 8, and 70% of Texans support significant limits on abortion generally (prohibition or narrow exceptions like the mother's life and health, rape, or incest).[4] This is an increase from a University of Texas/Texas Tribune poll in June 2021 that found 44% support for even the poorly worded "making abortion illegal after six weeks of pregnancy."[5]

In the findings section of SB 8, Texas asserted its "compelling interests from the outset of a woman's pregnancy in protecting the health of the woman and the life of the unborn child."[6] Texas, like a dozen other states,[7] passed a law prohibiting physicians from performing abortions after a fetal heartbeat is detected, around six weeks' gestation. In every one of those states, the law has been challenged and immediately enjoined. What made the Texas law different is the lack of government enforcement,[8] which is why it is the only Heartbeat Law currently in effect. As the first of these laws to survive a pre-enforcement challenge, SB 8 provides us with a glimpse of what a post-*Roe* world would look like.

Under our federalist system, Texas has authority to create and enforce laws that improve the health and welfare of its citizens, including the youngest members of the human family. SB 8 is the policy preference of the voters of Texas, regardless of its popularity on Capitol Hill.

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[4] University of Houston Hobby School of Public Affairs & Texas Southern University Barbara Jordan-Mickey Leland School of Public Affairs, *Texas Trends Survey 2021* (Oct. 2021) https://uh.edu/hobby/txtrends/txtrends2021_report1.pdf.

[5] The Texas Politics Project at the University of Texas at Austin, *Support or Oppose: Making Abortion Illegal After 6 Weeks of Pregnancy* (June 2021) https://texaspolitics.utexas.edu/set/support-or-oppose-making-abortion-illegal-after-6-weeks-pregnancy-june-2021.

[6] Tex. Health & Safety Code § 171.202(3).

[7] Alabama (total prohibition, Ala. Code § 26-23H-4), Arkansas (heartbeat and 12 weeks, Ark. Code § 20-16-1304), Georgia (heartbeat, Ga. Code § 31-9B-2), Iowa (heartbeat, Iowa Code § 146C.2), Kentucky (heartbeat, Ky. Rev. Stat. § 311.7706), Louisiana (heartbeat, La. Stat. tit. 40 § 1061.1.3), Mississippi (heartbeat, Miss. Code § 41-41-34.1), Missouri, (8 weeks, Mo. Rev. Stat. § 188.056), North Dakota (heartbeat, N.D. Cent. Code § 14-02.1-05.2), Ohio (heartbeat, Ohio Rev. Code § 2919.193), Oklahoma (heartbeat, Okla. Stat. tit. 63 § 1-731.3), South Carolina (heartbeat, S.C. Code § 44-41-680), Tennessee (heartbeat, Tenn. Code § 39-15-216).

[8] Tex. Health & Safety Code § 171.207(a) ("Notwithstanding Section 171.005 or any other law, the requirements of this subchapter shall be enforced exclusively through the private civil actions described in Section 171.208. No enforcement of this subchapter, and no enforcement of Chapters 19 and 22, Penal Code, in response to violations of this subchapter, may be taken or threatened by this state, a political subdivision, a district or county attorney, or an executive or administrative officer or employee of this state or a political subdivision against any person, except as provided in Section 171.208.").

Because Texas collects and reports abortion data each month, we already know that SB 8 is having an effect. In September 2021, abortion was down 50% from September 2020.[9] While some women may travel out of state to obtain an abortion, many will not, meaning that thousands of lives will be spared from the violence of abortion. As data becomes available from Texas' neighboring states, and more babies are born, we will have a better understanding of the long-term impacts of SB 8.

II. Women deserve better than abortion.

In the past two decades, the abortion rate has steadily fallen, dropping below its pre-*Roe* rate.[10] The current abortion rate is nearly half what it was at the high point in the 1980's.[11] Increasingly women reject abortion, recognizing the humanity of their unborn child and taking advantage of the resources available to help them parent or adopt.

Pregnancy resource centers play a central role in empowering women to choose life. Many secular and faith-based nonprofits in Texas stand ready to assist women, providing free resources, counseling, and material support. In fact, Texas has over 200 dedicated pregnancy centers, more than any other state.[12]

According to CareNet and the Charlotte Lozier Institute, pregnancy centers served 178,724 Texans in 2019.[13] This included:

- $19,448,790 in medical services like pregnancy tests, ultrasounds, and STI testing
- $10,889,759 in family services like counseling, parenting education, and post-abortion support
- $2,218,416 in material items like diapers, clothing, and car seats.

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[9] Kari White et al., *Initial Impacts of Texas' Senate Bill 8 on Abortions in Texas and at Out-of-State Facilities*, Texas Policy Evaluation Project at The University of Texas at Austin (Oct. 2021) http://sites.utexas.edu/txpep/files/2021/10/sb-8-initial-impact-oct-28-txpep-brief.pdf.
[10] Katherine Kortsmit et al., *Abortion Surveillance—United States, 2018*, 69 Surveillance Summaries 1 (Nov. 27, 2020) https://www.cdc.gov/mmwr/volumes/69/ss/ss6907a1.htm.
[11] *Id.*
[12] Caroline Kitchener, *With Most Abortions Illegal in Texas, Crisis Pregnancy Centers See an Opportunity*, THE LILY (Sept. 4, 2021) https://www.thelily.com/with-most-abortions-illegal-in-texas-crisis-pregnancy-centers-see-an-opportunity/.
[13] CareNet & Charlotte Lozier Institute, *Pregnancy Center State Impact Report* (Oct. 2021) https://s27589.pcdn.co/wp-content/uploads/2021/10/Final-Texas-State-Impact-Report_2019-Data.pdf.

This year, Texas again increased funding for its Alternatives to Abortion[14] program, allocating $100 million over the upcoming biennium.[15] Run through the Texas Department of Health and Human Services, the program provides material support and connects families in need with referrals for government assistance programs for which they are eligible. Additionally, 73 federally qualified health centers operating more than 660 service delivery sites serve Texas women and families across the state.[16]

SB 8 is giving some people flashbacks to earlier Texas litigation. In 2013, there were around forty abortion clinics in Texas.[17] After the legislature enacted a law requiring hospital admitting privileges to ensure continuity of care if a complication occurred during the abortion, over half of these clinics closed. They never reopened even after the law was struck down, and the remaining 19 Texas abortion businesses fear the same will happen now.[18] In reality, when women and families are offered other options, they take them. The industry is failing in Texas because demand has dropped. In 2008, Texas reported 81,591 abortions done in the state; by 2020, that number was 56,358.[19]

In *Planned Parenthood v. Casey*, a plurality of the Court relied on the mistaken belief that people (primarily women) have made choices about their intimate lives with the understanding that abortion exists as a fallback if contraception fails and to remove that option would cause grave harm.[20] But five decades of Court-sanctioned

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[14] Alternatives to Abortion, Tex. Health & Hum. Servs., https://www.hhs.texas.gov/services/health/women-children/alternatives-abortion (last visited Nov. 2, 2021).
[15] Shannon Najmabadi & Carla Astudillo, *An Anti-Abortion Program Will Receive $100 Million in the Next Texas Budget, But There's Little Data on What's Being Done With the Money*, THE TEXAS TRIBUNE (June 8, 2021) https://www.texastribune.org/2021/06/08/texas-abortion-budget/.
[16] Texas Department of State Health Services, *Texas Primary Care Office (TPCO) – Federally Qualified Health Centers* (Apr. 23, 2021) https://dshs.texas.gov/TPCO/fqhc/.
[17] Julia Harte, *Texas Abortion Clinics Struggle to Survive Under Restrictive Law*, REUTERS (Sept. 30, 2021) https://www.reuters.com/world/us/texas-abortion-clinics-struggle-survive-under-restrictive-law-2021-09-30/.
[18] *Id.*
[19] Induced Termination of Pregnancy, ITOP Statistics (2021) https://www.hhs.texas.gov/about-hhs/records-statistics/data-statistics/itop-statistics.
[20] 505 U.S. 833, 856 (1992). ("To eliminate the issue of reliance that easily, however, one would need to limit cognizable reliance to specific instances of sexual activity. But to do this would be simply to refuse to face the fact that, for two decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail. The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives. . . .The Constitution serves human

abortion merely show that "choice" encourages employers, sexual partners, and even women themselves to serve a business-oriented, profit-driven market over their families or their own self-interest.[21] In her new book, pro-life feminist Erika Bachiochi quotes pro-choice law professor Deborah Dinner's condemnation of so-called choice as she points out "The discourse of reproductive choice continues to legitimate workplace structures modeled on the masculine ideal [with no caregiving responsibilities] as well as social policies that provide inadequate public support for families."[22]

How often do pro-choice politicians prioritize abortion over authentic choices? If abortion is a "choice," employers and the government[23] can offer to pay for the cheaper, easier option—the one that most benefits them—while claiming the mantle of "women's equity."[24] Last month the Biden administration rolled out its "National Strategy on Gender Equity and Equality," which included warnings about the "grave threats to reproductive rights."[25] With abortion standing strong as one party's solution to all women's problems, how can we possibly come together to promote policies that support working moms and families?

III. The Supreme Court can—and should—revisit abortion jurisprudence later this year.

On December 1, 2021, the Supreme Court of the United States will hear oral arguments in *Dobbs v. Jackson Women's Health Org.*[26] and consider the question

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values, and while the effect of reliance on *Roe* cannot be exactly measured, neither can the certain cost of overruling *Roe* for people who have ordered their thinking and living around that case be dismissed.") (citation omitted).

[21] Erika Bachiochi, *The Feminist Revolution Has Stalled. Blame* Roe v. Wade, AMERICA: THE JESUIT REVIEW (Nov. 1, 2021) https://www.americamagazine.org/politics-society/2021/11/01/roe-wade-casey-texas-heartbeat-law-241725.

[22] *Id.*

[23] Steve Daines & James Lankford, *Radical Expansions of Taxpayer-funded Abortions in Democrats' Multi-Trillion Dollar Tax & Spend Reconciliation Bill* (Nov. 1, 2021) https://www.daines.senate.gov/imo/media/doc/Radical%20Expansions%20of%20Taxpayer-funded%20Abortions%20in%20Democrats'%20Multi-Trillion%20Dollar%20Reconciliation%20Bill.pdf.

[24] Fact Sheet: National Strategy on Gender Equity and Equality, The White House (Oct. 22, 2021) https://www.whitehouse.gov/briefing-room/statements-releases/2021/10/22/fact-sheet-national-strategy-on-gender-equity-and-equality/.

[25] National Strategy on Gender Equity and Equality, The White House, https://www.whitehouse.gov/wp-content/uploads/2021/10/National-Strategy-on-Gender-Equity-and-Equality.pdf.

[26] No. 19-1392 (2021).

presented: Whether all pre-viability prohibitions on elective abortions are unconstitutional.

The Court can—and should—take the opportunity to recognize the unsettled nature of *Roe v. Wade*[27] and *Planned Parenthood of Southeastern Pennsylvania v. Casey*[28] and return lawmaking to legislators. Indeed, as Americans United for Life outlined in one of the two briefs we filed in *Dobbs:*

> The standard of review for abortion regulations has bounced around, case by case, from *Roe* to *June Medical* [*Services v. Russo*].[29] Aside from the constantly shifting standard of review, *Roe* is radically unsettled for additional reasons. It has not received the acquiescence of Justices or lower court judges. *Roe* was wrongly decided and poorly reasoned. Numerous adjudicative errors during the original deliberations—especially the absence of any evidentiary record—have contributed to making *Roe* unworkable. It has been the subject of persistent judicial and scholarly criticism. There is a constant search for a constitutional rationale for *Roe*, and the Court has yet to give a reasoned justification for the viability rule.[30] *Casey* is unsettled by its failure to ground the abortion right in the Constitution, by an ambiguous standard of review that is unworkable, by conflicting precedents that have "defied consistent application" by the lower courts, and by persistent judicial and scholarly criticism.[31] Politics aside, reconsidering *Roe* and *Casey* does not involve uprooting a stable, settled feature of the legal landscape. Because they are radically unsettled, *Roe* and *Casey* contradict the stare decisis values of consistency, dependability, and predictability and are entitled to minimal stare decisis respect.[32]

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[27] 410 U.S. 113 (1973).
[28] 505 U.S. 833 (1992).
[29] 140 S. Ct. 2103, 2182 (2020) (Kavanaugh, J., dissenting) ("Today, five Members of the Court reject the *Whole Woman's Health* cost benefit standard."); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2321 (2016) (Thomas, J., dissenting); *Casey*, 505 U.S. at 999 (Scalia, J., concurring in the judgment in part and dissenting in part) ("Has *Roe* succeeded in producing a settled body of law?"); *Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 461 & n.8 (1983) (O'Connor, J., dissenting); *Carey v. Population Servs. Int'l.*, 431 U.S. 678, 704 (1977) (Powell, J., concurring in part and concurring in the judgment).
[30] *See* Randy Beck, Gonzales, Casey *and the Viability Rule*, 103 Nw. U. L. Rev. 249 (2009).
[31] *Payne v. Tennessee*, 501 U.S. 808, 828–830 (1991).
[32] Brief of Americans United for Life as *Amicus Curiae* in Support of Petitioners at 2–3, *Dobbs v. Jackson Women's Health Organization*, No. 19-1392 (2021).

The viability rule was dictum in *Roe*, since neither Texas's nor Georgia's statutes was tied to viability.[33] "Neither Congress nor state legislatures are bound by language unnecessary for a decision, however strong,"[34] yet courts have held firm to a viability rule that does not allow the state to introduce evidence of a compelling interest that might outweigh the viability line.[35]

At present, the government's ability to prohibit abortion before viability hinges on the litigiousness of those who oppose the law. No amount of scientific evidence or public outcry can move a judge who feels he or she is bound by the viability line of *Casey*. In practice, the viability rule functions more as a "standard, except when it isn't." One-third of the states have pain-capable laws (20 weeks' gestation) currently in effect because they have not been challenged.[36] Perhaps this is because opponents of these laws fear the Court may have revisited *Casey* sooner.

Lower courts are split on whether laws prohibiting discriminatory abortions on the basis of prenatal diagnosis of Down syndrome or other fetal anomalies run afoul of the viability line, meaning that about half of such laws are enjoined and half are in effect.[37] Again, the viability standard creates a messy, inequal outcome and hamstrings states from acting upon their well-established compelling interest in preventing discrimination.

Indeed, the United States House of Representatives voting on HR 3755, the "Women's Health Protection Act," suggests that Leadership recognizes the end of *Roe/Casey* is nigh and lawmaking will finally be returned to lawmakers.

IV. The so-called Women's Health Protection Act, Congressional Democrats' response to Texas SB 8, would trample any pretense of federalism, effectively banning all state abortion regulations and forcing every state to have abortion on demand throughout pregnancy.

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[33] Parts of an opinion are dicta if they are "not essential to [the court's] disposition of any of the issues contested." *Central Green Co. v. United States*, 531 U.S. 425, 431 (2001).
[34] Henry J. Friendly, *Time and Tide in the Supreme Court*, 2 Conn. L. Rev. 213, 216 (1968).
[35] Brief *Amici Curiae* of 228 Members of Congress in Support of Petitioners at 6–7, *Dobbs v. Jackson Women's Health Organization*, No. 19-1392 (2021).
[36] *Id.*
[37] Compare *Preterm-Cleveland v. McCloud*, 994 F.3d 512, 517–18 (6th Cir. 2021) with *Little Rock Fam. Plan. Servs. v. Rutledge*, 984 F.3d 682, 690 (8th Cir. 2021).

The Women's Health Protection Act does everything but protect women's health. It impedes the States' legitimate interest in protecting life, attempts to negate currently existing commonsense protections for women's health, and prohibits any such protections from being enacted in the future.

The Act would significantly limit the States' ability to enact desperately needed public policy that furthers the Supreme Court-sanctioned goals of protecting the health and safety of women and girls and valuing human life. By banning virtually all state laws before viability, the Act would prevent basic regulation and oversight crucial to keeping women safe.

The invalidation of SB 8 would just be the beginning. Here are some of the hundreds of health and safety laws that could be invalidated by WHPA:

- **Gestational age limits:** 43 states and counting[38] have laws that restrict elective abortions at or before "viability" based on women's health and the interests of the child.[39]
- **Fetal pain:** Currently 18 of those states limit abortion to 20 weeks' gestation based on scientific evidence that the baby can feel pain.[40]
- **Discrimination:** Every state would be prohibited from preventing discriminatory abortions on the basis of race, sex, or genetic anomaly.
- **Informed consent:** Most states have enforceable informed consent and reflection period laws.
    - 28 states require written materials be either given or offered.[41]
    - 25 states require specific information be given on the abortion procedure.[42]

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[38] New Hampshire Governor Sununu signed a 24 weeks' law this year which will take effect on Jan. 1, 2022.

[39] Michelle Ye Hee Lee, *Is the United States One of Seven Countries That "Allow Elective Abortions After 20 Weeks of Pregnancy?"*, THE WASHINGTON POST (Oct. 9, 2017) https://www.washingtonpost.com/news/fact-checker/wp/2017/10/09/is-the-united-states-one-of-seven-countries-that-allow-elective-abortions-after-20-weeks-of-pregnancy/.

[40] Brief *Amici Curiae* of 228 Members of Congress in Support of Petitioners at 6–7, *Dobbs v. Jackson Women's Health Organization*, No. 19-1392 (2021).

[41] These states are Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, West Virginia, and Wisconsin.

[42] These states are Alabama, Alaska, Arizona, Arkansas, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Utah, and Wisconsin.

  - 31 states require the woman be informed of the probable gestational age of her fetus.[43]
- **Reflection periods:** 26 states have a reflection period[44] like Pennsylvania's 24-hour law upheld by the Supreme Court in *Casey*.[45]
- **Prohibiting telemedicine abortion:** 7 states have already explicitly prohibited at-home abortions via telemedicine.[46] And around twenty states have laws requiring that abortion-inducing drugs be prescribed and supplied directly from the physician in a clinical setting.[47] Texas joined them when Governor Abbott signed SB 4 this summer.

According to Section 2(a)(9) of the WHPA, nearly 500 state laws to regulate abortion have been passed since 2011. This year, at least 22 states have enacted restrictions on abortion.[48] The WHPA seeks to invalidate most of them. The argument that abortion is a constitutionally protected right and therefore must be protected by the federal government means States would have virtually no say in enacting abortion laws. This bill pushes federal power over the power given to the States.

As if stripping many robust protections from existing state law is not enough, the WHPA also prohibits regulations of abortion providers that could be considered, in the loosest possible terms, a restriction on an individual from having an abortion. The Act thereby engenders a regulatory regime that is akin to the one in Pennsylvania that allowed the infamous abortion provider Kermit Gosnell to operate his "House of Horrors" for many years. Gosnell, who was ultimately convicted of involuntary manslaughter, was able to provide unsafe, unsanitary, and deadly abortions for many years because, according to the Grand Jury report, the Pennsylvania Department of Health thought it could not inspect or regulate abortion

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[43] These states are Alabama, Alaska, Arizona, Arkansas, Connecticut, Florida, Georgia, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wisconsin.

[44] These states are Alabama, Arizona, Arkansas, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wisconsin.

[45] *Casey*, 505 U.S. at 844.

[46] These states are Arizona, Idaho, Montana, Ohio, Oklahoma, West Virginia, and Wisconsin.

[47] Amanda Stirone, *State Regulation of Telemedicine Abortion and Court Challenges to Those Regulations*, 24 On Point (July 2018), https://s27589.pcdn.co/wp-content/uploads/2018/07/State-Regulation-of-Telemedicine-Abortion-and-Court-Challenges-to-Those-Regulations.pdf.

[48] Ams. United for Life, State Legislative Sessions Report (2021) https://aul.org/2021/10/27/auls-2021-state-legislative-sessions-report/.

clinics because that would interfere with access to abortion.[49] By lowering professional accountability, abortion providers will be free to operate without regulation and oversight, to the detriment of women and young girls.[50]

V. *Roe* and its progeny never created an unfettered "right to abortion."

From its inception in *Roe v. Wade*, the abortion "right" has been explicitly qualified. While the Court established a constitutional "right" to abortion, it simultaneously expressed that "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that [ensure] maximum safety for the patient."[51] Affirming what is considered the essential holding of *Roe*, the Supreme Court in *Planned Parenthood v. Casey* asserted that "it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy. . . . The woman's liberty is not so unlimited, however, that from the outset [of pregnancy] the State cannot show its concern."[52]

Over the past five decades, the Supreme Court has, at various points, yielded back authority to the States, recognizing their many important interests surrounding abortion. As recently as 2020, the Supreme Court reverted to the more permissible *Casey* standard after several years of *Hellerstedt*.[53] Indeed, the Justices exercised restraint in only addressing the standing issue as ripe and permitting SB 8 to take effect while the Court continues to hear challenges to the law.[54]

The American people, through their elected officials, recognize the need for basic oversight, for genuine informed consent, and for the interests of the child to factor in at some point in pregnancy, even if we disagree on when that is. It is certain Members of Congress who are out of step with the American people and the biological reality that a preborn child is a member of the human family, not the other way around.

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[49] *See, e.g.*, Conor Friedersdorf, *Why Dr. Kermit Gosnell's Trial Should Be a Front-Page Story*, ATLANTIC (Apr. 12, 2013), https://www.theatlantic.com/national/archive/2013/04/why-dr-kermit-gosnells-trial-should-be-a-front-pagestory/274944/ (discussing the case of Kermit Gosnell).
[50] *See, e.g.*, Ams. United for Life, UNSAFE (3d ed. 2021) (documenting unsafe practices of abortion providers and harm to women's health and safety).
[51] *Roe*, 410 U.S. at 150.
[52] *Casey*, 505 U.S. at 869.
[53] *See June Med. Servs. v. Russo*, 140 S. Ct. 2103 (2020).
[54] *Whole Woman's Health v. Jackson*, No. 21-463 (argued Nov. 1, 2021), *United States v. Texas*, No. 21-588 (argued Nov. 1, 2021).

The "right" to abortion in this country has never been unqualified or unregulated. This term it will likely be modified once again by the Supreme Court that created it. Removing every medical component of the abortion procedure in the name of unfettered "access" isn't women's health—it's just abortion.

VI. Conclusion

The outcome of enacting this radical regime of abortion on demand across the country would be truly devastating. Communities would be unable to act if a Gosnell or Klopfer set up shop. States would be unable to protect women from bad doctors and unsanitary clinics. Emergency protections and basic informed consent would be stripped away. Women suffering complications would be abandoned, reliant only on emergency rooms with no continuity of care. And complications would increase as the procedure is de-medicalized by doctors who now say they don't even need to see a patient in person or independently verify pregnancy before prescribing chemical abortion pills.[55]

Congress expresses policy preferences in the bills it considers and the hearings it schedules. This hearing says that browbeating duly elected Texas lawmakers and the constituents who elected them is more important than funding the government or overseeing the administrative. The WHPA says that speedy abortions are valued over women and girls' health and safety. That at no point in pregnancy do the child's interests come into play. That the States, who broadly enact and enforce local healthcare regulations, no longer have a say in this one area of medicine. That more babies being born, and more resources being allocated to support women, children, and families, is "devastating" to certain members of this committee.

Congress—and the Supreme Court—should let Texans govern Texas.

Sincerely,

Catherine Glenn Foster
President and CEO
Americans United for Life

[55] Elizabeth G. Raymond et al., *No-Test Medication Abortion: A Sample Protocol for Increasing Access During a Pandemic and Beyond*, 101 Contraception 361 (June 2020).

Chair NADLER. Thank you.
Ms. Piñeiro, you are recognized.

STATEMENT OF STEPHANIE LORAINE PIÑEIRO

Ms. PIÑEIRO. Good afternoon, Members of the Committee. Thank you for the generous invitation to speak to you about the State of abortion access in Florida.

My name is Stephanie Loraine Piñeiro and I work as the Co-Executive Director of the Abortion Fund, Florida Access Network.

I'm a storyteller with We Testify, a Puerto Rican poderosa, a survivor of sexual assault, [speaking foreign language], a bisexual woman who has had two abortions and as a social worker with a Master's degree from the University of Central Florida.

Mr. JOHNSON of Georgia. Thank you, Mr. Chair.

Chair NADLER. Yes? Oh. I'm sorry, Ms. Piñeiro.

Mr. JOHNSON of Georgia. Okay. Am I on now?

Chair NADLER. The clerk will restart the clock and, Ms. Piñeiro, you may start again.

Ms. PIÑEIRO. Thank you.

Good afternoon, Members of the Committee. Thank you for the generous invitation to speak to you about the State of abortion access in Florida.

My name is Stephanie Loraine Piñeiro and I work as the Co-Executive Director of the Abortion Fund, Florida Access Network. I'm a storyteller with We Testify, a Puerto Rican poderosa, a survivor of sexual assault, [speaking foreign language], a bisexual woman who has had two abortions and a social worker with a Master's degree from the University of Central Florida.

As proud as I am to testify today, I am dismayed that I'm here to explain why we must continue to defend our constitutionally-protected right to abortion.

As a result of the Supreme Court's inaction, SB 8 was allowed to go into effect, adding yet another burden for people who want abortions. This emboldened States like my home State of Florida, who wasted no time in introducing an almost identical six-week ban.

I am worried about our future and what it means for people who need abortions today, tomorrow, and for years to come. I know what it is like to want an abortion only to be tripped up by medically unnecessary restrictions and financial barriers.

When I was a teenager, I became pregnant twice, once as a result of a rape, and again during a relationship when I was 17 years old. Both times I knew I wanted an abortion.

After my rape, I felt ashamed, and I blamed myself. I know now that being raped was not my fault, and wanting an abortion is nothing to be ashamed of regardless of how someone becomes pregnant.

Before my second abortion when I was 16, my Catholic pediatrician refused to prescribe me birth control against my request. A year later, when my then boyfriend tried to purchase Plan B, the pharmacist refused to sell it.

After I was denied Plan B, I spent weeks waiting for my period and searching the internet for clues about how I could self-manage my own abortion. I was afraid of violence escalating in my already

unsteady home and about what could happen if I told my very strict parents that I needed another abortion.

Like 72 million Americans, my family was enrolled in Medicaid. Because of the Hyde Amendment, my abortions were not eligible for coverage. When I had my abortions, I was a high school student working as a waitress and helping my family during the recession, earning $2.17 an hour as my base pay, which is still the Federal minimum wage for tipped restaurant workers.

I had to pick up extra shifts just to afford the $450 for my appointment. I shouldn't have been forced to choose supporting my family—between supporting my family and paying for my abortion.

Because Florida has a parental involvement law, I had to skip class to go to court and ask a judge, a complete stranger, for permission to end my pregnancy through a process called judicial bypass. With the help of my lawyer, I presented myself in a five-page essay as mature enough not to parent a child when I didn't want to.

Between the appointments with my attorney, the whole ordeal took several weeks and delayed my abortion even more. A decade after my experience, I co-authored a groundbreaking report entitled, "The Judicial Waiver Process in Florida Courts," If/When/How, Lawyering for Reproductive Justice, which analyzed whether Florida courts could offer clear and unbiased information about the judicial bypass process.

We found that over half of Florida's 67 counties could offer little or no information about the process, and one county clerk even tried to talk a caller out of their abortion decision.

This is what I see every day at the Florida Access Network. We take calls from people who need help getting to a clinic and paying for their abortions. We help people with rides or gas money to get to their appointments.

We help coordinate their childcare. We help people with lodging when they have to travel long distances, and we help young people navigate the judicial bypass process.

Since 2015, we have supported nearly 2,000 people offering an average of $100 to help people meet the financial gap for their abortions, which cost on average $600 without insurance coverage.

We fund abortion because low wages, abortion restrictions, like SB 8, and policies like the Hyde Amendment make abortion unattainable. Without the communities of support, we have created to relieve the burdens people face trying to access healthcare, no one should be turned away from healthcare that they want because they can't afford it.

As I close, I want to remind the Committee Members of your responsibility to protect our right to have abortions free from undue burdens, shame, and stigma.

You have the power to change the lives of millions of people in this country by enacting legislation that stands up for the dignity of every person who seeks an abortion.

As we say at We Testify, everyone loves someone who has had an abortion and that includes every single one of you. To the people listening who have had or will have abortions, you are supported, you are loved, and I will never stop fighting for you.

Thank you for listening to my story and I hope you remember that the actions you take impact your constituents and your loved ones who have had abortions.

Thank you.

[The statement of Ms. Piñeiro follows:]

Stephanie Loraine Piñeiro, MSW
Co-Executive Director, Florida Access Network
Abortion Storyteller, We Testify

U.S. House of Representatives Committee on the Judiciary Hearing:
"The Texas Abortion Ban and its Devastating Impact on Communities and Families"

November 4, 2021

Written Testimony

Good morning distinguished members of the committee. Thank you for the generous invitation to come speak to you about the state of abortion access in Florida. My name is Stephanie Loraine Piñeiro and I am the co-executive director of the abortion fund Florida Access Network, a storyteller with We Testify, a Puerto Rican poderosa, a surivivor of sexual assault, a bisexual woman who has had two abortions, and a social worker with a masters degree from the University of Central Florida. As proud as I am to testify before you today, I am dismayed that I am here to explain why we must continue to defend our constitutionally protected right to abortion which is healthcare protected by decades of settled law.

On September 1, as a result of the Supreme Court's inaction, the most restrictive abortion ban in the United States, Texas' SB8, was allowed to go into effect, adding yet another barrier for people who want to have an abortion as early as six weeks. The law has cut abortions in half[1] in two months, meaning people who wanted abortions were turned away from clinics and forced to travel out of state for care or forced to continue their pregnancies against their will. On Monday, the Supreme Court Justices heard oral arguments on the impact that the law has had on Texans. If that wasn't scary enough, we're already we're seeing states like mine, Florida, working to enact a similar law to ban abortion. I am worried for our future and what it means for people who need abortions today, tomorrow, and the years to come. I know pregnant Floridians are worried too.

I don't have to imagine their pain, I know what it is like to want an abortion, only to be tripped up by medically unnecessary restrictions and financial barriers. You see, when I was a teenager, I became pregnant twice, once as a result of a sexual assault and again during a relationship when I was 17. Both times I knew I wanted an abortion but abortion stigma coupled with financial and logistical barriers made access difficult and ultimately delayed. The first time I needed an abortion was the day I realized I'd been sexually assaulted while I was in a vulnerable state. I was confronted with the reality that many people who've been sexually assaulted face, one where I blamed myself. I felt ashamed about what happened to me and I felt ashamed of needing or wanting an abortion as a result. I know now that being sexually assaulted was not my fault and that wanting or needing an abortion is nothing to be ashamed of regardless of how someone becomes pregnant.

Prior to my second abortion, when I was 16, my Catholic pediatrician refused to prescribe me birth control against my request. A year later, when my then-boyfriend tried to purchase Plan B, the pharmacist refused to sell it despite the law changing a month prior allowing over-the-counter purchasing. After I was denied Plan B, I spent the next two weeks waiting to know whether I would become pregnant and searched the internet for clues about how I could end my own pregnancy if I needed to, even if that meant I would risk my life doing so. I was afraid of violence escalating while living in an already unsteady home and I was afraid of what could happen when I told my very traditional Latino parents that I needed an abortion, again.

I've been failed by this nation's healthcare system. Like 72 million Americans, my family was enrolled in Medicaid, but because of the Hyde Amendment, my abortions were not eligible for

[1] Abortions Fell by Half in Month After New Texas Law - The New York Times

coverage under this health insurance. It took me several weeks to save up enough money to be able to afford the procedure. During my second abortion, I was a dual enrolled college and high school student working as a waitress to help my family during the recession. I only earned $2.17 an hour as my base pay—which is *still* the federal minimum wage for tipped restaurant workers—and I had to pick up extra shifts just to earn the $450 for my abortion.

I could not safely go to my parents for help with my abortion and because Florida has a parental involvement law, I had to skip class to go to court and ask a judge—a complete stranger—for permission to end my pregnancy through a process called "judicial bypass." I had to present myself, in a five page essay, as mature enough not to parent a child when I didn't want to. The whole ordeal took several weeks and delayed my abortion even more. If a law like SB8 had been in effect in Florida, I would not have been able to get my abortion in my community.

A decade after obtaining my judicial bypass, I co-authored a groundbreaking report with If/When/How Lawyering for Reproductive Justice examining court preparedness in Florida as it pertains to providing clear, consistent, accurate, and unbiased information about the judicial waiver process. Researchers telephoned all 67 Florida counties seeking information about the judicial waiver process and classifying just 11 as "prepared or knowledgeable" about the process. Another 15 counties were classified as "semi-prepared," demonstrating "a degree of knowledge about aspects of the process, but…unable to provide information sufficient enough to assume a young person would be able to proceed with the information provided." The remaining 37 Florida counties could offer little or no information about the process, and one court staffer attempted to dissuade the If/When/How caller from choosing abortion. The judicial waiver process is itself a barrier to abortion and adding more restrictions is simply an exercise in creating more burdens for young people who must be able to self-determine their reproductive lives without navigating a labrynthine court system where even well-intentioned staff are under- and untrained to offer assistance.

The truth is, I didn't realize how much of an injustice all of this was until five years after my second abortion when I began my abortion advocacy work. I was lucky to have been granted a judicial bypass and to be able to afford my abortion, but I know this is not the reality for many people around the country, and even more if laws like SB8 are enacted in other states.

In Florida, we're at risk of seeing a six week abortion ban enacted. This ban—which is really a two week abortion ban because we often don't know we're pregnant until a missed period four weeks later—is an injustice. Florida's anti-abortion lawmakers have employed diverse tactics to restrict abortion access and now have stacked the State Supreme Court with a anti-abortion majority that is ready to reinterpret the state's constitutional right to privacy as another tactic to restrict abortion. The state's constitutional right to privacy, which has protected Floridians from many of the abortion restrictions faced by our neighboring southern states, is hanging on by a thread. Anti-abortion legislators are committed to passing whichever abortion restrictions will stick, whether it's six weeks or 15-weeks, all of these restrictions ban on abortion for someone.

This isn't an abstract idea. It is what I do every single day through my work at the Florida Access Network (formerly known as the Central Florida Women's Emergency Network) founded in 1996 as a national response to abortion access needs. Our mission is to build pathways for abortion access by advocating for reproductive justice, funding abortion care, and providing logistical support to people who need abortions. Florida Access Network was a volunteer organization until 2020 when I became one of our first staff members. Since my entry to Florida Access Network in 2015, we have helped 1,870 people pay for their abortions and have offered over $200,000 in funding for our clients. Our pledges average about $100, while the average cost of an abortion in Florida is $600. We can help, but we cannot fill the gap making abortion unattainable for too many.

We help people with rides or gas money to get to their appointments because, according to the Guttmacher Institute, 73% of Florida counties have no abortion clinics[2]. We help coordinate childcare because, as you know, most people who have abortions are already parenting. We help young people under 18 navigate the complicated judicial bypass process if they cannot safely express their desire to have an abortion with their guardian. And, most importantly we fund abortion because low wages, abortion restrictions like SB8, and policies like the Hyde Amendment make abortion unaffordable and unattainable without mass resources and the ability to travel outside of our communities.

The majority of people who have abortions are people of color, and a quarter of abortion patients are Latinx[3], like me. Latinx people are not a monolith, but we do deeply value family and supporting one another through challenging moments. We do not support laws that would allow our loved ones to be sued for helping us get the abortion care we need. These abortion restrictions impact us hardest—they're designed that way. The abortion bans are racist because they deny Black and Brown people, and anyone who cannot afford it, the ability to decide if, when, and how to create and grow their families. Abortion bans like this stem from a white supremacist desire to control Black and Brown people, not allow us to determine our own futures.

I've helped hundreds of people access their abortions. I hear their stories, directly from them, and they know deeply what is best for them and their families especially their decision to have the abortions they need — if only their Congressional representatives would learn to trust them.

All of you in this room have the power to pass legislation to ensure that we are able to access abortion care, as promised to us by the Constitution, and by nature of healthcare being a basic human right. Together, we can make abortion care accessible, affordable, and stigma free because needing and having an abortion is nothing to be ashamed of.

As we say at We Testify, everyone loves someone who had an abortion. Thank you for listening to my story, and I hope you remember that the actions you take impact your constituents and loved ones who have abortions, and all of us across this nation. Thank you for listening.

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[2] State Facts About Abortion: Florida | Guttmacher Institute
[3] Induced Abortion in the United States | Guttmacher Institute

Chair NADLER. Thank you all for your testimony. We will now proceed under the five-minute rule with questions. I will recognize myself for five minutes.

Dr. Moayedi, how has SB 8 impacted abortion care in the communities you care for in Texas?

Dr. MOAYEDI. Thank you for that question, Representative.

SB 8 has completely decimated abortion access in my State and in the communities that I take care of. I every day almost am getting calls from my colleagues in the Dallas/Fort Worth area asking how to take care of the patients that they serve.

People with devastating pregnancy diagnoses, whether it's for the pregnancy itself or for them unable to get care in our State, people with very severe chronic medical conditions with no other options, and just my neighbors, my colleagues and friends that have unintended pregnancies and have nowhere to turn to.

We are working tirelessly to get people out of State, to help coordinate their care out of State. It's a nightmare. I have never thought that medical care would come to this.

Chair NADLER. Ms. Piñeiro, SB 8 has had ripple effects across the country. Can you give us a brief overview of what it looks like for someone in Florida, especially someone who's struggling to make ends meet, to seek an abortion? If SB 8 in Texas remains in effect, what does this mean for Floridians and people in other States seeking abortions?

Ms. PIÑEIRO. Abortion restrictions in Florida look like people like me on a Saturday morning sitting in my client's car babysitting her child because she didn't have access to childcare because she was busy working to try to support her family.

It's interesting hearing the Committee talk about people's lives like they're so frivolous. Abortion restrictions impact people who are lied to by anti-abortion pregnancy centers about the gestational age.

Abortion patients in clinics and providers are moving targets for harassment and clinics are targeted by the State and forced to endure unnecessary regulatory restrictions in having an abortion.

Thank you.

Chair NADLER. Thank you.

Professor Bridges, during this hearing, I expect we will hear false claims, comparing abortion to eugenics and our country's history of slavery. Can you share your perspective on those claims?

Dr. BRIDGES. Absolutely. Thank you so much for that question.

Those claims proceed from a misunderstanding of what eugenics was about. Eugenics was about State control of reproductive decisions. Eugenics was about the State deciding who could and could not become parents, who would and would not be a good parent.

That's not at all what abortion is about today. Abortion is about people exacting a modicum of control over their lives, deciding to terminate a pregnancy because it is in their best interest. It is in the best interest of their children, meaning that many of the people who have abortions are already parents.

So, the comparison to eugenics is not that abortion today is eugenics. In fact, abortion restrictions today are comparable to eugenics in as much as abortion restrictions consists of the State determining what people will and will not do with their reproductive

life. It's the State deciding who will become a parent, even though those people do not desire to become a parent themselves.

So, again, the comparison isn't apt. Abortion is not eugenics. Abortion restrictions are more akin to eugenics.

Thank you.

Chair NADLER. Thank you very much.

Ms. Fischbach?

Ms. FISCHBACH. Thank you, Mr. Chair.

I am just a bit curious what the purpose of today's hearing is. We're talking about a State law that is currently under review by the Supreme Court, and the Supreme Court will decide if the law is constitutional and only the Supreme Court, not the House Judiciary Committee.

That being said, we are here with a Texas State law in front of us. This law is currently in effect, and it is saving lives. It is saving the lives of unborn babies.

Women and babies deserve better than being told that their only option is abortion. Many pro-life groups and individuals across the country reach out to pregnant women to help with support, diapers, housing, and with love.

Abortion does not help women.

After saying that, I have a couple of questions for Ms. Foster.

Ms. Foster, first, thank you for being here. I appreciate the time you took and in sharing the information with us.

In your experience, is it accurate to characterize elective abortion as healthcare?

Ms. FOSTER. It is not.

Ms. FISCHBACH. Thank you. Does that term accurately reflect what happens to a baby?

Ms. FOSTER. Healthcare?

Ms. FISCHBACH. Yes, during abortion.

Ms. FOSTER. Absolutely not. Absolutely not.

Ms. FISCHBACH. Maybe I should go back. Many of the Members and Witnesses present today have vigorously objected to the Heartbeat Law recently passed by Texas.

The people of Texas chose through their duly-elected officials to protect unborn babies at that point, when a beating heart can be detected. How early can the fetal heartbeat be detected?

Ms. FOSTER. Frequently, as early as 6–8 weeks.

Ms. FISCHBACH. Are there any other things you can tell us about a baby that is going on at that gestational age?

Ms. FOSTER. Absolutely. At that point, you can see the beginnings of their arms, hands, legs, feet, hearing the heartbeat, and seeing the formation of their head and their features.

We're talking about a human being. Life is not frivolous. That's the entire point here, and that child in the womb who is developing, who generally by the time that you hear that heartbeat that child will be viable—that pregnancy will be viable, and so the chances that she or he will grow to full term are very good at that point.

Ms. FISCHBACH. Ms. Foster, I wasn't necessarily going to do it, but I did bring along a 10-week model and just to show that it's got—you can't see it, but he's got fingers and toes and it looks a

lot like a little baby to me. It saddens me when we cheapen life through abortion and just in general.

Just one final question Ms. Foster. You've written about providing alternatives to abortion, real alternatives, and it's necessary to really create a culture that allows for an understanding of motherhood and that is inclusive of women's hopes and dreams.

Let's support women and not push them towards the violence and neglect of abortion. How can we as a nation better provide for women facing those unexpected pregnancies with real choices?

Ms. FOSTER. Yes. There are so many ways that we can really stand with women in need and partners in need and support them. That involves governmental methods and nonprofits that are actively working in communities throughout our nation, outnumbering abortion facilities in the hundreds to thousands and are providing real alternatives or providing material resources like diapers, clothing, formula, and car seats, you name it—that are providing things like career training, parenting training, and are just providing that hope and support, encouraging women that—of course, as we know, the primary three reasons why women seek abortion, whether we're talking about first trimester or late term—from the abortion industry's own published studies—there are financial concerns, relationship issues, and not feeling ready to be a parent.

All three of those areas are areas where we can come alongside women and stand with women and be there for them, and that is what pregnancy resource centers are doing in the thousands in communities throughout our nation, and that's what even we have government resources for. It's to stand with the disenfranchised and with the vulnerable and provide hope and support.

Ms. FISCHBACH. Thank you very much.

I would just say in closing, I think that would be a much better use of the Committee's time to be looking at what we can do to help instead of going through a law that is sitting in front of the Supreme Court and they will make the determination of its constitutionality.

Thank you, Mr. Chair. I yield back.

Chair NADLER. The gentlelady yields back.

Ms. Jackson Lee?

Ms. JACKSON LEE. I thank the Chair very much.

I have the Constitution in my hand. I just want to quickly read the Ninth Amendment. The enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by the people. We clarify and characterize that as the right to privacy, which has not been undermined.

Professor Bridges, my time is short, so very carefully, is any law that you know dealing with abortion rights, *Roe* v. *Wade*, and others forcing women to get an abortion? Is this required? Are they hauled into a physician's office? Or is this protection for their choice and their right to privacy?

Professor Bridges?

Dr. BRIDGES. Thank you for the question. No, no one's being coerced into an abortion.

Ms. JACKSON LEE. So, today, I want to focus on legislation that I have that I'm very grateful that many Members of the Judiciary

Committee have decided to join and we hope more will, the Preventing Vigilante Stalking That Stops Women's Access to Health Care and Abortion Rights. Again, H.R. 5710, Preventing Vigilante Stalking That Stops Women's Access to Health Care and Abortion Rights.

Doctor, a new study by Dr. David Eisenberg, a board-certified obstetrician/gynecologist, and I think this has an overall impact, estimates the Texas SB 8's new restrictions on women's health could cause increases in maternal mortality, already high, of up to 15 percent overall and up to 33 percent for Black women.

Can you focus on the outright horror of what it means to have a private citizen, even if you don't know the particulars, a private citizen to have the capacity to stalk you and to receive money on your bounty in terms of the provider and/or the woman?

Dr. Moayedi?

Dr. MOAYEDI. Thank you so much for the question, Representative.

I don't have to imagine what it's like to have violent people stalking me because that is actually my life every single day as an abortion provider in Texas.

I am followed into my job. I am screamed at. My child is screamed at by people that purport to love children. I get hate messages and death threats to my home simply for caring for my community.

So, it's very disturbing for me personally to hear people proclaim to be pro-life while they actively threaten my life and my child's life. This law—yes, ma'am?

Ms. JACKSON LEE. Would Federal law to prevent this kind of stalking, at least give you a sense that the Federal government understands how criminal that behavior is, even though it's a private citizen? Would a Federal law prevent that?

Dr. MOAYEDI. I'm not a politician and so I don't really understand the ins and outs of a policy like that. I know that there are Federal laws right now that should prevent these people from blocking access to our clinics and harassing our patients, but it does not.

So, I welcome any opportunity to make our clinics more secure from violent protesters and to make my life safer from violent people. I'm just not sure what the right answer is.

Ms. JACKSON LEE. Well, the stalking law is different. It stops people from stalking you under the Federal stalking law. Would that help you?

Dr. MOAYEDI. I hope it would. I'm not sure. What I understand from stalking is that it has to be very persistent and routine, and so it is often very hard for us now even to get the FBI or local police departments to care about the current harassment that we get.

Ms. JACKSON LEE. I appreciate it. That would change.

Professor Bridges, the same. As you well know, not since the fugitive slave law have, we had this independent bounty hunting going on.

Very briefly, would a modification of the Federal statute on stalking to stop people who are stalking you to prevent you to get health information on abortions, would that help? The whole bill needs to be eliminated, but would that help overall?

Dr. BRIDGES. I would have to see the text of the bill that addresses stalking for me to offer a formal opinion and for me to determine whether it will, in fact, help.

I welcome any effort that will help people in Texas and people across this country exercise their constitutionally-protected right to terminate a pregnancy before viability.

Ms. JACKSON LEE. Thank you.

Let me say to Stephanie, let me thank you for your courage. You should not have faced what you faced. I would simply raise the question, being in Florida as well, what do you think of a law that now is being promoted in other States that gives a private citizen, in addition to what you had to go to, expose yourself in court, but a private citizen the right to stalk you and get a bounty? What does that do to your privacy?

Ms. PIÑEIRO. It scares me. It scares the people that I support every day to get an abortion. I also welcome any legislation that would support with protecting clinic entrances.

I will say that, unfortunately, people break the law every day, right, so enacting a law that would criminalize this behavior would be great. It wouldn't eliminate stalking from happening.

Chair NADLER. The time of the gentlelady has expired.

Mr. Chabot?

Ms. JACKSON LEE. Thank you for your answer.

Mr. CHABOT. Mr. Chair, nearly 50 years ago, the Supreme Court handed down one of its most controversial ever decisions, *Roe* v. *Wade*. Since that ruling, there have been over 60 million abortions in this country, 60 million innocent lives ended before they even had a chance. That's over a million abortions each year since this slaughter was legalized back in 1973 on January 22nd, which happens to be my birthday.

Planned Parenthood alone performs over 320,000 abortions each year. That is approximately the population of my hometown, Cincinnati, Ohio. So, Planned Parenthood, essentially, wipes out the equivalent of the population of Cincinnati every year, year after year.

Mr. Chair, life is precious, and we should do all we can to protect it. Since I was elected here, I have been involved in a whole range of pieces of legislation. I introduced the ban on partial birth abortion, for example, which President Bush signed into law. It went all the way to the U.S. Supreme Court. They upheld it and it is now the law of the land. There are still far too many abortions in this country.

The legislation that we are discussing today is Texas law SB 8, and it would effectively, of course, ban abortions after a heartbeat is detected in the womb. This legislation has been described by many in the media as "extreme and unprecedented." In reality, we have been discussing a ban on abortions after a heartbeat for years. In fact, 13 States, including my home State of Ohio, have enacted some form of legislation which prohibits abortions if a heartbeat is detected. There is the Federal Heartbeat Protection Act, which Mike Kelly, a member of this institution has cosponsored, along with many of us, and a number on this Committee. Mr. Chair, banning abortions after a baby's heartbeat is detected is neither extreme nor unprecedented.

I will tell you something that is extreme, and that is allowing a massive abortion outfit, like Planned Parenthood, to kill the equivalent of Cincinnati's population every year. Something else that is extreme is witnessing Members on the other side of the aisle abandoning the Hyde Amendment, which has enjoyed bipartisan support for 40 years now and has saved nearly 2.5 million lives. Getting rid of the Hyde Amendment will force American taxpayers to pay for other people's abortions.

Even though the radical left is fully in control in the House and in the Senate and in the White House, States and local governments are fighting back. In addition to the heartbeat bills that we have already mentioned, earlier this year, two cities in my Congressional District, Lebanon, and Mason, became the first cities in Ohio to pass an ordinance making them pro-life sanctuary cities and forbidding abortions within their city limits. I applaud the leaders in both of those communities for taking that brave stance. I hope others will follow that example.

Mr. Chair, we need to be direct and honest about what is being discussed here today. Abortion is not healthcare. It is a barbaric procedure that ends the life of an unborn baby. By 10 weeks, an unborn baby has arms and legs and fingers and toes, and among other things, he or she can such their thumb, stretch, jump when startled. In short, these babies are alive, and they deserve our protection.

Ms. Glenn Foster, let me ask you this: One of our other Witnesses has already, quite astonishingly, said that abortion is an act of love. Is that your opinion?

Ms. FOSTER. It is not. Life is not frivolous. Abortion is not healthcare. That is the whole point.

I never thought that I would hear an OB/GYN tell this Committee that dismembering a fellow human being is an act of love, an act of freedom. We can and we must do better.

Mr. CHABOT. Thank you.

You mentioned the dismemberment abortion. When we passed the Partial Birth Abortion Ban Act, we knew we were stopping thousands of abortions each year, but we knew there were other forms. I know it is pretty horrific, but could you describe, essentially, what a dismemberment abortion is, which is still legal in this country?

Ms. FOSTER. Certainly. It involves inserting tools into the uterus, into the womb, to literally rip a child apart limb from limb. That is really the crux of it.

Mr. CHABOT. Pretty horrific stuff. These babies, oftentimes, are capable of feeling pain, is that correct?

Ms. FOSTER. Absolutely. If you are doing prenatal surgery, then, not only do you provide anesthesia to the mother, but you also treat the baby's potential pain.

Mr. CHABOT. One last question. I am almost out of time. We are trying to protect both the health of the woman and the baby, is that right? We are trying to protect both?

Ms. FOSTER. Yes, and the majority of Americans understand that, when we pass pro-life laws, that is what we are doing. We are protecting both mother and child.

Mr. CHABOT. Thank you very much. I yield back.

Chair NADLER. The gentleman yields back.

Mr. Johnson?

Mr. JOHNSON of Georgia. Thank you, Mr. Chair, for holding this hearing.

Professor Bridges, let's start with the obvious. Texas' law known as SB 8 bans abortion at, roughly, six weeks of pregnancy. Isn't SB 8 a clear violation of the right to abortion prior to fetal viability, that right having been established under *Roe* v. *Wade* and reaffirmed in *Planned Parenthood* v. *Casey*, and most recently, in 2018, in June *Medical Services* v. *Russo*?

Dr. BRIDGES. Absolutely. In the words of Justice

Sotomayor, SB 8 is "flagrantly unconstitutional." Nevertheless, it is in effect.

Mr. JOHNSON of Georgia. So, it would be fair to say that SB 8 is actually blatantly constitutional—blatantly unconstitutional? Sorry.

Dr. BRIDGES. Absolutely. Every superlative I have for you, blatantly, flagrantly, obviously, undeniably, all of them.

Mr. JOHNSON of Georgia. Well, Professor Bridges, what do you make of the United States Supreme Court's decision to allow the blatantly unconstitutional SB 8 to remain in effect while its constitutionality is challenged in the lower courts?

Dr. BRIDGES. I take that to be a sign that the Supreme Court has backed away from its role as the apolitical branch of government. While the Executive and Legislative branches are supposed to be the political branches, the Judiciary is supposed to be the apolitical branch. Nevertheless, the Supreme Court is making decisions that reveal that it is being motivated by raw political will, raw political power.

Mr. JOHNSON of Georgia. Well, Professor Bridges, was it extraordinary for the Supreme Court, without full briefing, without oral argument, and without even the dignity of a reasoned opinion, to use its shadow docket to temporarily allow the State of Texas to deny a recognized constitutional right to nearly 1 out of every 10 women of reproductive age in this country?

Dr. BRIDGES. Absolutely. It was extraordinary, it was egregious, and it was extreme. I would note that, prior to September 1, very few people would have imagined that the Supreme Court would let a flagrantly constitutional law go into effect, when it had the power to enjoin it.

Mr. JOHNSON of Georgia. In fact, Professor Bridges, by allowing SB 8 to remain in effect during the pendency of the challenge to its constitutionality, the Supreme Court itself ignored stare decisis and denied every woman in the entire State of Texas a fundamental constitutional right, isn't that correct?

Dr. BRIDGES. That is correct. The Supreme Court backed away from its own established precedents, its own established precedents even regarding the shadow docket, which is to preserve the status quo. The Supreme Court allowed the status quo to change, and in allowing the status quo to change, it allowed for the infringement of a Texan's right to terminate a pregnancy before viability.

Mr. JOHNSON of Georgia. You have touched on this, Professor Bridges. Does the Supreme Court's decision to allow SB 8 to re-

main in effect indicate how this ultraconservative majority will approach future abortion cases?

Dr. BRIDGES. Oh, it sends the strongest signal I can imagine about how the Supreme Court feels about abortion rights, which are still fundamental rights under the U.S. Constitution. The Supreme Court's holding in *Whole Woman's Health* v. *Jackson*, its decision to let that flagrantly unconstitutional law go into effect, reveals that the Supreme Court does not care much for the abortion right; they will not protect the abortion right in the same way that it will protect other rights that it favors.

Mr. JOHNSON of Georgia. Thank you, Professor.

SB 8 is touted as protecting women, when, in fact, it is doing nothing more than attempting to control, criminalize, and dehumanize women and their ability to exercise control over their reproductive health.

Ms. Piñeiro, thank you for sharing your story here with us today. Based on your experiences, what substantive effects would the outcome that Professor Bridges just discussed have on individuals in your State?

Ms. PIÑEIRO. People in the State of Florida are already facing restrictions to abortions. Florida has a 24-week gestational ban already in place, and any delay in abortion care should be and remain unconstitutional.

Mr. JOHNSON of Georgia. Thank you. With that, I yield back.

Chair NADLER. The gentleman yields back.

Mr. Gohmert?

Mr. GOHMERT. Thank you, Mr. Chair.

Thank you to the Witnesses for testifying today.

Dr. Moayedi, as I understood from your testimony, you have done late-term abortions, correct?

Dr. MOAYEDI. Sir, that is not a medical term, but I provide abortion care, yes.

Mr. GOHMERT. Even past 22 weeks at times, when it is allowed, right?

Dr. MOAYEDI. Depending on the jurisdiction in which I'm providing care, yes, sir.

Mr. GOHMERT. Right. Yes.

We had some years back—some of you all may remember—a person who had provided late-term abortions. It is interesting, yes, in the medical field, there are terms; in the legal field, there are terms.

He described in detail—I think he said he had done over a thousand late-term abortions, or if you would prefer, dismemberment abortions—and he described in much greater detail, Ms. Foster, about the instrument that was used to insert into the womb. He described how he would feel around for something linear, and the longer linear, he knew was a leg. He would clamp on, and he described in detail how he would pull that leg out of socket and pull it from the body, and then, how he would find another linear object about the same length, rip that off of the body, and then, look for, feel around for two shorter linear items, knowing those were the two arms; rip them out from the body.

Once they were removed, he said in his words he "would feel for something bulbous," and you know that was the skull. You would

clamp onto the skull and crush it, because the child's head would not come through the uterus that was at that point not dilated. It would be easier, once you had crushed the skull—yanked it away from the body, then pull the body out.

For some of us, that is considered—and I know Dr. Moayedi used the term "hateful and cruel" with regard to the Texas law—but some of us would describe that procedure of ripping arms and legs and the head off of a baby as being a bit hateful and cruel.

We have also heard reference to your position being somewhat hateful and cruel. Ms. Foster, do you disagree that mothers who are carrying a child that they didn't expect or did not deserve to be loved?

Ms. FOSTER. Of course. Absolutely.

Mr. GOHMERT. Have you provided help to mothers in that condition?

Ms. FOSTER. I have, and in a variety of ways. First, I was myself in that position when I was 19 years old. I needed that help and love. I did not find it. So, I have spent the years since trying to be that hope and help and love to other women and other families.

I served as chair of the board of a pregnancy center for a number of years. I still continue to serve on that board. I have volunteered with numerous other pregnancy centers. I have sidewalk counseled. I have reached out to women and families in my communities and simply served as a safe space and a sounding board and a resource. So, when people found themselves in an unexpected situation, they would be able to find out more and get information about where to go.

Mr. GOHMERT. Thank you.

Dr. Moayedi, when you have done abortions, is there another physician there or are you the only medical doctor involved in the abortion?

Dr. MOAYEDI. I'm a Doctor of Osteopathic Medicine.

Mr. GOHMERT. Okay.

Dr. MOAYEDI. Depending on where I provide abortion care, there might be another physician in the room or not.

Mr. GOHMERT. Yes. I was just curious because when my wife had my first daughter—she is amazing—when she was born very prematurely, we had the OB/GYN, and we also had a pediatrician there whose sole goal and job was to protect the entrance of our child. He did an amazing job. It required hospitalization and intubation, and all kinds of things. I'm so thankful we had a pediatrician there looking out for the interest of the child and an OB/GYN looking out for the mother. I commend that to everyone else.

I yield back.

Chair NADLER. The gentleman yields back.

Ms. Bass

Ms. Bass, you should unmute yourself.

Ms. BASS. I'm so sorry. Sorry about that.

Thank you, Mr. Chair, for conducting this important hearing, and to the Witnesses, for your testimony here today.

It is not lost on me that we are here discussing a bill that empowers, essentially, vigilantes to circumvent the rights of others. I really wanted to ask one of the Witnesses, Professor Bridges, if you could talk about that, that aspect of the bill. Then, also, put it in

its historical context in terms of that type policing and the impact that that is going to have, and how you imagine that is going to play out in the State of Texas.

Dr. BRIDGES. Yeah. Thank you so much for that question.

So, what—and the term that you use, "vigilante justice," is precisely what I would use to describe what's going on in Texas. Essentially, the State is allowing—the Supreme Court has allowed the State to allow private citizens to police, to terrorize, and to control the bodies of other private citizens.

That is precisely how we would describe chattel slavery in this country, for example. The State was permitted to allow private citizens to police, terrorize, control the bodies of the other human beings who they considered to be property.

I will also note that the analogy is not an epithet at all because part and parcel of chattel slavery was the control of people's reproductive lives. It was because humans were property, it was an incentive of the people who purported to own that property to coerce the birth of more property. So, the State allowed private citizens to coerce birth from people. That's precisely what's happening in Texas.

Ms. BASS. Well, but let me just ask you, because that doesn't apply to everyone.

Dr. BRIDGES. Uh-hum.

Ms. BASS. I don't think it applied to everyone back in the days of enslavement, and I don't know of the vigilantism that is okay in this bill applies to everyone, either. For example, I don't know to the extent that would apply to a woman who was particularly affluent. I don't exactly know, and maybe you can describe a little bit about that.

I also think it is ironic because, right now, they just finished picking the jury in the Ahmaud Arbery trial, and that as, to me, exactly that type of vigilantism. The young man was jogging, and he was, essentially, gunned down because they assumed that he had done something wrong.

So, how does it even work in the bill? How is somebody supposed to know the woman in that car, where she is going?

Dr. BRIDGES. Right. You've just got to guess. The thing is that the bill incentivizes people to guess, to attempt to reap the monetary rewards of a successful lawsuit.

One thing that I just want to mention, thank you for bringing up Ahmaud Aubrey. It's such a tragedy, but at least his family has the ability to try to seek justice in the court. What the Supreme Court has done—up until right now, we're still in a world in which the Supreme Court has boxed individuals out of the Federal judiciary. There's nowhere where we can seek recourse. So, that is why Congress has to act.

Ms. BASS. Well, I wanted to know, also, if you could talk about maybe other aspects of this history in the criminal justice system. I mean, you mentioned the period of enslavement, but I want to know if you could describe other times. If you could also speak about how abortion bans and restrictions are already used to criminalize people accessing abortion, and how it could get worse, if *Roe* is overturned?

Dr. BRIDGES. Right. I mean, so I spoke about chattel slavery, but we know that that history extends well beyond chattel slavery throughout reconstruction. It took a civil rights movement before people of color were granted formal citizenship. So, private actors were permitted to control their lives.

I want to spend some time, though, talking about how bans and regulations like SB 8 move abortion access out of the hands of the most marginalized people. What that means is those with privilege, as you gestured to before, are able to travel to Kansas; they're able to travel to Oklahoma, and they're able to travel to my State of California. They are exercising their constitutional rights, albeit burdened. The most marginalized aren't able to do that. What that means is that they're resorting to methods that have been criminalized, especially in Texas.

Ms. BASS. Well, I actually wonder whether an affluent woman would have to leave the State. Because I would imagine that a woman of affluence could have that type of care right there in the State of Texas.

Dr. BRIDGES. Absolutely. We know that in the pre-*Roe* era people were able to get abortions from their obstetrician.

Ms. BASS. All right. Thank you. I'm out of time.

Dr. BRIDGES. Thank you.

Chair NADLER. The gentlelady yields back.

Mr. Issa?

Mr. ISSA. Thank you, Mr. Chair.

Professor Bridges, you are familiar with a great deal of constitutional law. Would you say that the decisions decided by the Supreme Court against President Trump were appropriate in deciding the questions of the election?

Dr. BRIDGES. I am a constitutional law scholar, but I do not do—my expertise is not in election law.

Mr. ISSA. I understand, but you are at UC Berkeley. You are a professor. You did note those decisions, didn't you? Did you think that they were reasoned? Did you have any objections to them?

Dr. BRIDGES. I could speak about how I felt about them from a layperson's perspective. Because I'm not an election law scholar, I can't speak on the well-reasoned nature or not of those decisions.

Mr. ISSA. Thank you.

Ms. Foster, do you find it interesting that everyone seems to have an opinion that the Supreme Court is extreme and biased when it comes to one issue, but this would be no exception. Anytime the Court seems to rule against what conservatives would like, I hear nothing that they are well-reasoned and balanced. Do you find that humorous, even from your position, not as a scholar in that area?

Ms. FOSTER. It certainly is interesting. As we heard earlier, Chuck Schumer stood on the steps of the Supreme Court on March 4, 2020, and threatened Justices Gorsuch and Kavanaugh, prompting a rare public response from the Chief Justice who called the remarks "inappropriate and dangerous."

We see these transparent efforts to bully the Supreme Court into issuing opinions that serve certain policy goals, rather than interpreting the Constitution. I believe we should all be raising our sights. We know that too much of life in Washington can feel like

political theater. They need not be that way. We can all care about women here today, and we do, but truth here must start with the stopping of abortion.

Mr. ISSA. To that extent, it is interesting to me that the Associated Press and the University of Chicago found that 65 percent of Americans said abortion during the second trimester was wrong, and 80 percent in the third trimester. It's interesting that more than half of the Witnesses and more than half of the people here on this dais have the exact opposite opinion as 80 percent of Americans, including President Biden who, unlike the Chair, has expressed skepticism in court packing as a solution.

I want to play something for the record here very quickly.

[Audio played: "Our vision should be of an America where abortion is safe and legal, but rare."]

Mr. ISSA. Did you hear anything today from the majority that implied that they agreed with President Clinton on the "rare" part of abortion?

Ms. FOSTER. It seems like today the focus is on making abortion legal and ubiquitous, but certainly not rare, and as we all too often see, not safe. We need a Court that is concerned with justice.

Mr. ISSA. Well, in speaking of justice, look, I'm from a State where even trying to provide abortion alternatives, even making young pregnant in need aware of families who would adopt their child and give them a good home, is discouraged and sometimes prohibited. So, I'm not from a State that is like Texas.

Looking at Texas and Florida for a moment, did Texas and Florida—Florida, for example, at 22 weeks, is it consistent with the *Roe* decision? Is Florida in that part of its law looking at viability and setting a number which is certainly viable with today's science?

Ms. FOSTER. Absolutely. Florida—Florida's law regarding late-term abortions is completely in line with the Constitution. It's completely in line with viability and the limits set by *Roe* v. *Wade* and *Planned Parenthood* v. *Casey*, and it is in line with the opinion of the vast majority of Americans, including Democrats and self-described pro-choice Americans.

Mr. ISSA. So, today, we are hearing something that is inconsistent with 80 percent of Americans; we are hearing testimony, except for yours, that implies extreme by a Court that has been well-balanced, and we are hearing that somehow it is extreme to set 22 weeks, a point at which babies are regularly born alive and well, is somehow wrong. Isn't that what we are hearing here today?

Ms. FOSTER. That is what we're hearing, and there is nothing more tragic than abortion killing when a child can already definitively survive. There is no medical basis for killing a child at 22 weeks or later, absolutely none, and you don't need to be a doctor to make that decision or judgment. You simply need to be a human being.

Mr. ISSA. Thank you, Mr. Chair. I rest my case.

Chair NADLER. The gentleman's time has expired.

There is a series of Floor votes. A series of votes have started on the Floor. So, the Committee will be in—do you think we can do one more? Okay, we will do one more.

Mr. Jeffries?

Mr. JEFFRIES. Thank you very much, Mr. Chair, for convening this incredibly important hearing.

Ms. Foster, the Texas law doesn't start at 22 weeks, is that correct, in terms of its restriction?

Ms. FOSTER. That is correct.

Mr. JEFFRIES. It starts at six weeks, is that true?

Ms. FOSTER. It does.

Mr. JEFFRIES. Okay. So, I'm not really certain what the prior conversation was about.

Mr. ISSA. Would the gentleman yield?

Mr. JEFFRIES. No, I won't.

Under the Texas abortion ban, someone who misses that six-week window would be forced to carry their pregnancy to term, even if they were raped, is that correct?

Ms. FOSTER. Under the Texas law, that, the protections for the mother and for the child start with that detection of the heartbeat at six weeks, yes.

Mr. JEFFRIES. All right. So, there is no exception beyond the six-week period for rape, correct?

Ms. FOSTER. When we are talking about rape, it is a horrible tragedy, period. There are no ifs, ands, or buts about that, and we need to rid the world of those kinds of actions. Nowhere in our justice system is there ever a time when the innocent has to pay for the crime of another, for the crime of the father. The killing of a baby for the crimes of his or her father is never justice. In fact, that's injustice.

Mr. JEFFRIES. All right. The question is, is there a rape exception? The answer is no. The question, that is interesting because you with my former colleagues about public sentiment. Are the actions of rape exception popular among the American people or even the people in the great State of Texas?

Ms. FOSTER. Yes, 55 percent of Texans support the heartbeat law, let alone something as far along as 22 weeks. So, yes, most Americans and most Texans do support this heartbeat law.

Mr. JEFFRIES. Okay. That is very inconsistent, and that wasn't an answer to the question that I asked.

Let's go to another particular issue. If someone misses this six-week window, and the pregnancy resulted from incest, would they still be forced to carry that baby to term?

Ms. FOSTER. Again, I would simply say the child does not deserve the death penalty for the father's crime. So, the heartbeat bill is protecting children from the moment that that heartbeat is detected.

Mr. JEFFRIES. Right. So, there is no incest exception in the Texas so-called statute, is that correct?

Ms. FOSTER. Wouldn't that fall under rape as well?

Mr. JEFFRIES. It is a yes-or-no question.

Ms. FOSTER. Correct.

Mr. JEFFRIES. Is there an incest exception, yes or no?

Ms. FOSTER. There is no specific incest exception, but the child does not deserve to die because of the crime of a father.

Mr. JEFFRIES. Okay. Professor Bridges, let me ask you a question, picking up on a theme that my colleague Karen Bass was pursuing with you in terms of criminalization. Would the outlawing of

abortion and restricting the reproductive freedom of women, as is being done in a very extreme and Draconian way in Texas, would that have a disproportionately adverse impact on Black women?

Dr. BRIDGES. Absolutely. This is true for a number of reasons.

(1) Black people disproportionately bear the burdens of poverty. So, that means, (2) that they proportionately—they have higher rates of unintended pregnancy, which is the main reason why people choose to exercise their constitutional right to terminate a pregnancy.

Moreover, if they do not have the right to legally terminate a pregnancy, that means that people will resort to things that have been criminalized. We know—just look across the country—that even though we have race-neutral criminal statutes, statutes that are supposed to apply to everyone equally, people of color are those who are disproportionately arrested, indicted, convicted, incarcerated under our criminal laws. So, any criminal law, at least, can expect to have a disproportionate impact on people of color.

Mr. JEFFRIES. Well, thank you very much.

Just in closing, I know my colleague talked about the issues in terms of the Supreme Court. I respect all my colleagues on both sides of the aisle, as we debate and discuss all these issues. Part of the challenge that many of us have with this current extreme, right-wing Supreme Court is that, engineered by Mitch McConnell, he stole, not one, but two Supreme Court Justices—one from President Obama and the other from President Biden—explicitly, to jam these types of extreme laws down the throats of the American people.

Mr. ISSA. The gentleman's time has expired.

Mr. JEFFRIES. Thank you very much, and I yield back, Mr. Chair, Jerry Nadler.

Chair NADLER. The gentleman yields back.

A series of votes have been called on the House Floor. Therefore, the Committee will take a recess and we will return immediately after the conclusion of these votes.

The Committee stands in recess.

[Recess.]

Chair NADLER. The Committee will come to order.

Before we begin, I want to apologize to our Witnesses for the lengthy and unexpected break for votes. We appreciate your staying with us so we can continue this important hearing.

Mr. Jeffries was the last—so Mr. Johnson of Louisiana.

Mr. JORDAN. Mr. Chair?

Chair NADLER. Mr. Jordan?

Mr. JORDAN. Yes, Mr. Chair, our Witness was unable to stay. Frankly if we had started this Committee on time, we would have got to hear from her. She was doing an amazing job. Started two hours late and then the Democrats add votes during the vote series that weren't scheduled and now we have no Witness.

Chair NADLER. Well, your staff indicated that was fine at the time.

Mr. JORDAN. Indicated what was fine at the time? You starting the Committee two hours late?

Chair NADLER. Yes, we had a Democratic caucus, and we informed your staff, and they indicated it was fine.

Mr. JORDAN. Not aware of any indication to that effect at all. All I know is our Witness can't be here. She had family commitments she had to get back home for.

Chair NADLER. I am sorry. I don't know what the—we have three Witnesses here.

Mr. JORDAN. No, the point is—

Chair NADLER. I don't know what the alternative is.

Mr. JORDAN. —when you schedule a hearing, it is not the Republican's fault or the Republican-invited Witness's fault that you guys don't have the votes for this package that is going to harm the country. That is not our problem.

Chair NADLER. I am not going to get into the merits—

Mr. JORDAN. Now, we don't have a Witness.

Chair NADLER. I am not going to get into the merits of whatever we are doing other than the Committee right now. We have no alternative but to continue the hearing because when would we reconvene it?

Mr. JORDAN. Well, that is up to you. I don't get to schedule things, which again—

Chair NADLER. We are going—

Mr. JORDAN. If I get to schedule things, we would have started at 10:00 a.m.

Chair NADLER. Yes. Well, I didn't have that choice.

Mr. JORDAN. What do you mean? You are the Chair. Of course, you had that choice.

Chair NADLER. The hearing will continue.

Mr. Johnson of Louisiana?

Mr. JOHNSON of Louisiana. Thank you, Mr. Chair. Today our Democratic colleagues brought us here. We heard this morning before we had to break a lot of grandstanding about abortion rights, and we came here so they could criticize a State law rather than hold a hearing on several important legislative items that have long been-awaiting a hearing in this Committee on this very topic of abortion. We have a number of bills we would love to have heard.

My questions are for Ms. Moayedi, who boasted on her Twitter feed on October 26, complete with a dancing Egyptian princess meme, the following: Here it is. She said, "Some days I leave clinic and think damn, I really was put on this earth to be the best damn abortion provider this side of the Mississippi. Not a humble brag. That is a full on brag brag. I am that good. Three hearts."

Well, with those credentials, ma'am, I am really glad you are here, at least on video. I really wish I had a full day to ask you some questions, but let's start with the written testimony you submitted for this hearing. I have highlighted some of the truly incredible statements you made there.

The stunning irony of the opening of your fourth paragraph struck me. You wrote, "I want this Committee to spend a few moments thinking about what it's like to be a person needing abortion care in this country." So, just so I have this straight, you want us to, quote, "think about what it's like to be a person," really. What about those thousands of innocent pre-born children that you have been involved in the abortion of? What about them?

As the National Right to Life Committee summarized it so well, when a woman is pregnant science tells us that the new life she carries is a completely separate and fully new human being from the moment of fertilization. By the time most abortions can be performed the baby already has a beating heart and identifiable brain waves.

The baby living in her mother is as distinct and unique, a separate person, human being as I am from you. This human being like all of us has the unalienable right to life and deserves the full protection under the law. The baby that every mother carries as she faces life and death decisions has a beating heart at 22 days after fertilization, brain waves as early as six weeks after fertilization. Most abortions are not performed until at least after—on or after nine weeks of the pregnancy.

This is a model of a 10-week pre-born child. It obviously is a child. If you look at it at this stage, he or she has fingers and toes. They begin to practice breathing and facial expressions, even smiling. That is a very tiny person, ma'am. That is what we are talking about. So, yes, let's consider what it means to be a person.

Your written testimony goes on to describe the Texas Heartbeat Law as, quote, "incredibly wrong, hateful, and cruel, and dehumanizing" to the clients you serve. Again I would just ask—I would say really? Really? What about the brutal violence and the murder that is committed upon the pre-born child? That is the ultimate violation of human rights, the ultimate hateful and cruel act, the ultimate dehumanizing act. It is as if the world is upside-down.

I was particularly stunned to read the conclusion of your written testimony, ma'am, where you quoted—you said, quote, "Abortion is love. Abortion is a blessing." What a twisted thing it is to suggest that the murder of 62 million innocent pre-born children in this country is a blessing.

Whether you or your friends acknowledge it or not, abortion is the horrible violation of the most essential truths and commands of our Creator. Scripture clearly teaches and our Declaration of Independence plainly affirms a self-evident truth, not an opinion, but a self-evident truth that we are all created by God and given by Him the same inalienable rights beginning with the right to life.

Congress has a duty to protect these fundamental rights and the lives of the pre-born because they are unable to protect themselves. To put it bluntly, our duty is to protect these innocent children from the unimaginable callousness and barbaric violence that is done at the hands of the industry you represent.

All life is precious. Because we are all made in God's image every single one of us has inestimable dignity and value, and our value is not related in any way to the color of our skin, the ZIP Code we live in, how good looking we are, where we went to school. Our value is inherent because it is given to us by God. It is a biological reality that a pre-born child is a member of the human family and more and more the American people understand that.

On October 9, Ms. Moayedi, you tweeted, "It's okay and healthy to have sex for pleasure. Birth is punishment for pleasure." I want to make sure everybody knows the credentials of our Witnesses here.

Here is another one: October 13 somebody tweeted, "Was your abortion experience funny? If so, direct mail or email me at" their email address. You shared that tweet and you said, "I can't wait to read this piece," with three hearts.

Look, I think that says enough about the credentials and about the arguments that are being made here. I think the American people make the judgment for their self. Abortion is not funny. It is an unspeakable tragedy. I think this hearing is a mockery of it. I think the challenge to the Texas State law is wrong. I am out of time. I yield back.

Chair NADLER. The gentleman yields back.

Mr. Cicilline?

Mr. CICILLINE. Thank you, Chair Nadler for convening this important hearing and thank you to our Witnesses for being here today.

I am glad that this Committee is making clear the dire consequences of SB 8 for American women, women in Texas and the surrounding states, and across the country.

To be honest it is sort of disappointing that we need to convene this hearing at all or to have this debate because so many of us thought that this issue was well-settled law in the United States by the decision by the United States Supreme Court in *Roe* v. *Wade*. In fact, I am not alone in that conclusion. Fifty-eight percent of Americans are opposed to overturning *Roe* v. *Wade*, and 8 in 10 Americans support legal abortion. So, lots of people thought this was settled law.

I note that in her written testimony Ms. Foster says that the Supreme Court, and I quote, "can and should take the opportunity to recognize the unsettled nature of *Roe* v. *Wade* and *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*."

So, my first question is for you, Professor Bridges. Are *Roe* and *Casey* unsettled law in any way?

Dr. BRIDGES. Absolutely not. *Roe* v. *Wade* is half a century old. It is completely workable. The undue standard that *Casey* established for reviewing the constitutionality of abortion regulations that burden the abortion right, the fundamental right to abortion has been workable. We've been working it for 30 years. There's nothing unsettled about *Roe* or *Casey*.

Mr. CICILLINE. Thank you.

Dr. Moayedi, I hope I am pronouncing that correctly, we have heard a lot of misinformation about abortion care from the other side during this hearing today. Let me be clear: Abortion care is critical, often lifesaving healthcare. To start, is there any scientific or medical justification for a six-week ban on abortion?

Dr. MOAYEDI. There's no medical or scientific explanation or justification for any restrictions on abortion care. Abortion is exceedingly safe. It is lifesaving and it is critical to the health and safety of our families and communities.

Mr. CICILLINE. Is there any other misinformation about abortion care that you would like to correct for the record today?

Dr. MOAYEDI. Yes, most everything that has been spoke about abortion care. Especially I'm troubled by asking a lawyer earlier to answer questions about healthcare. I think that really speaks to

how some Members of this Committee feel about science and medicine in general.

I'll say that you cannot have birth and health [inaudible] without access to abortion care. It is not possible. Abortion care is lifesaving. The people I take care of trust me to listen to them and I trust them to make the best decisions for themselves and for their families.

When people come to see me, I offer them nonjudgmental, unbiased, nondirective information and education so that they can make decisions for themselves, and I trust them to make the right decisions for themselves.

Mr. CICILLINE. Thank you very much, doctor.

Ms. Piñeiro, thank you so much for your very powerful testimony and for being here today. Ms. Foster cited a number of justifications for the lack of a rape exception in SB 8, and as a sexual assault survivor I can only imagine how difficult it was to hear those answers and I would like to give you the opportunity to respond to anything Ms. Foster said with respect to this legislation having no rape exception. To be clear to require victims of sexual assault/rape, to compel them to give birth to the child of their assailant.

Ms. PIÑEIRO. Thank you for the question, Congressman, and I'm really glad that I'll have the opportunity to respond to it.

I as a survivor firmly feel both appalled and worried that elected officials would affirm that forcing survivors of incest and rape to remain pregnant is okay. I'm worried for many people in this country who need abortion care. I'm worried for the millions of survivors of incest and sexual assault that suffer every day at the hands of abusers, at the hands of stigma.

As I sat here listening to that, I think about all the women in my life I love who are also survivors who called to thank me today for sharing my testimony. Thank you.

Mr. CICILLINE. Thank you so much.

With that, Mr. Chair, I yield back.

Chair NADLER. The gentleman yields back.

Mr. Biggs?

Mr. BIGGS. Thank you, Mr. Chair.

This hearing today is another attempt by Democrats to promote and glorify abortion, and as Ms. Foster said, it is also to increase the number of abortions in this country.

Earlier this year President Biden sent a budget request to Congress that did not contain any pro-life protections and every President since Jimmy Carter has either requested pro-life protections or signed appropriations bills into law that contained pro-life protections. Senator Biden supported the Hyde Amendment, but President Biden has bowed to pressure and renounced the Hyde Amendment.

In June, House Democrats passed several appropriations bills that did not include any pro-life protections, protections that have historically received bipartisan support.

In September, House Democrats passed the Women's Health Protection Act of 2021, a misnomer as health protection inherently does not involve the taking of a life, which would codify into Federal law abortion on demand.

In fact, we have heard the abortion providers and supporters testify today that this is a safe medical procedure, and yet a safe medical procedure that has two healthy lives go into that procedure and yet only one comes out alive is not really healthcare, nor is it safe medical care. If the Women's Health Protection Act of 2021 were enacted, States would be prohibited from protecting unborn children at any stage of development. Only one Democrat voted against the bill. That is how far the Democrat Party has moved on this issue.

We heard a statement in OGR by a Witness; she said it again today that abortion is a blessing, an act of love. It is freedom. Unless you happen to be the baby in the womb. Then it is not so much of a blessing. Really?

Yet, that same Witness said that she has been stalked and she wants to make, quote, "I want to make my life safer from dangerous people," close quote. She should be safer from dangerous people. I agree with that. Just like the baby in the womb should be safe from her and dangerous people just like her.

So, ending the life of an unborn child should never be the easiest decision you make. Abortion is not a blessing; it is not an act of love or freedom. We should all reflect on Mother Teresa's words from her address at the National Prayer Breakfast. She said, quote, "I feel that the greatest destroyer of peace today is abortion. It is really a war against the child, a direct killing of the innocent child, murder by the mother herself. And if we accept that the mother can kill even her own child, how can we tell other people not to kill one another?" close quote.

The Democrat majority in this House is obsessed with abortion. It is obsessed with ensuring that States are unable to pass laws to protect the unborn. Well, we concede—not just concede, we champion, we shout from the rooftops that every life is precious and should be cherished.

In fact, the Declaration of Independence says, "We hold these truths to be self-evident, that all men are created equal. They are endowed by the Creator with certain unalienable rights, that among these are life, liberty, and the pursuit of happiness." You cannot have liberty unless you are alive, and you cannot pursue happiness unless you are alive. We must protect life, liberty, and the pursuit of happiness, and abortion does not protect any of these rights. It destroys these rights.

At the same Oversight Hearing one of the Witnesses referred to pro-life protections such as the Hyde Amendment as discriminatory, classist, and racist. A Member of this House stated that abortion restrictions are part of the intertwined systems of oppression that deny Black, Indigenous, and people of color of their constitutional rights.

Gloria Steinem claimed, quote, "I think there is a profoundly racist resistance to the continuation of the right to safe and legal abortion and we see that in the nature of the resistors and the nature of their politics," close quote. Nothing could be further from the truth. The Hyde Amendment and other pro-life protections are not racist; they actually save lives.

However, Margaret Sanger, the founder Planned Parenthood was a racist once saying, "We don't want the word to go out that we

want to exterminate the African-American population." I will submit into the record the document where she said that.

Yet, Democrats cannot stop defending Planned Parenthood. Instead of celebrating abortion we should all be united in working to preserve life.

I would ask Ms. Foster if she was here, but after eight hours of delays today our Witness is not here for me to ask certain questions. I can conclude, as I am sure she would, that—are we as a nation worse off because there are fewer abortions? The answer would be indeed yes. We are a stronger nation when we protect those that cannot protect themselves such as the unborn.

Mr. Chair, I submit to the record the following articles: One entitled, "Margaret Sanger Founded of Planned of Parenthood on Racism," another called, "Margaret Sanger's Racist Legacy Lives On at Planned Parenthood," and the third is, "Remove Statues of Margaret Sanger, Planned Parenthood Founder, Tied to Eugenics and Racism." I will yield back.

Chair NADLER. Without objection.

[The information follows:]

MR. BIGGS FOR THE RECORD

A

Margaret Sanger founded Planned Parenthood on racism

By Rebecca Hagelin -
Sunday, April 23, 2017
ANALYSIS/OPINION:

Editor's note: This column is part of a series by Rebecca Hagelin on the moral imperative of defunding Planned Parenthood.

Minorities crammed into impoverished areas in inner cities should not be having so many babies. And, of course, these minorities (including most of America's immigrants) are inferior in the human race, as are the physically and mentally handicapped. We should require mandatory sterilizations of those less desirable and promote easy access to abortion. And since sex should be a free-for-all, we must provide birth control and abortions to teenagers too. It's all for the greater good and for a more intelligent, liberated, healthier population.

Feel a bit enraged by the sentiments above?

They absolutely sicken me.

If you are feeling squeamish or angry too, then you should call your representatives in Congress and demand an end to your tax dollars funding Planned Parenthood. You also can sign the petition at LiveAction.org.

For such are the foundational beliefs of this inherently racist organization and its celebrated founder, Margaret Sanger, who still is lauded on the Planned Parenthood website. Of course, in the lavish online praise of Sanger, conveniently absent is her advocacy for "a stern and rigid policy of sterilization and segregation to that grade of population whose progeny is already tainted, or whose inheritance is such that objectionable traits may be transmitted to offspring." (The quote is from her article "A Plan for Peace.") Or her promotion of the "American Baby Code," in which she seeks to "protect society against the propagation and increase of the unfit."

Also missing is Sanger's fear of her racist views being exposed, as recorded in a 1939 letter to an ally: "We do not want word to go out that we want to exterminate the Negro population." Which is exactly what she set out and succeeded in doing.

Planned Parenthood is largely the reason why black babies are aborted in America three times more often than white babies, and Hispanic preborns are killed 1½ times more often than whites. In fact, according to Centers for Disease Control and Prevention research compiled by TooManyAborted.com, "Abortion is the number one killer of black lives in the United States. More than HIV. More than heart disease. More than cancer. Abortion snuffs out more black lives than all other causes of death combined."

Planned Parenthood masquerades as a benevolent organization, claiming to offer a full array of women's health care services to disadvantaged women. From the way Planned Parenthood markets itself, one would think it offers basics such as mammograms and prenatal health care — especially for poor women living in the nation's most impoverished neighborhoods.

But it does not. Mammograms are nowhere to be found. And, as LiveAction.org recently revealed in an extensive investigation in the 41 states where undercover recordings are legal, 92 out of 97 clinics contacted admitted that they do not provide prenatal care. The bottom line is that those ultrasound machines in Planned Parenthood are used to facilitate the killing of preborn babies, not care for them.

What Planned Parenthood does offer en masse in its "clinics" — which are strategically located in target areas such as college campuses and in impoverished, inner-city neighborhoods — are birth control and abortions. In fact, a baby is aborted at a Planned Parenthood clinic at an average rate of every 90 seconds.

Why college campuses? Why poor, minority inner-city neighborhoods?

Because Planned Parenthood holds a worldview that young women should be able to have sex without consequences or responsibility. Because Planned Parenthood wants these same young women to come back to their clinics for their abortions when the birth control fails. And because Planned Parenthood still seeks to provide abortions for minorities over whites. Today, Planned Parenthood may not be racist in its words, but it is still overtly racist in its deeds.

Thanks to the brilliant work of LiveAction.org, TheCenterforMedicalProgress.org and other truth seekers, we now know that Planned Parenthood traffics in human baby body parts, that it covers up the sexual trafficking of minors, that it engages in racist practices, that it provides birth control to underage girls without parental consent and that it does not provide the most basic of women's health care services.

America is better than this.

It's time for Congress to cut off funding to this shameful organization and direct our tax dollars to other clinics that offer life-giving health care services. Add your voice to the call to defund Planned Parenthood at www.LiveAction.org/petition/.

• *Rebecca Hagelin can be reached at rebecca@rebeccahagelin.com.*

A

Margaret Sanger's racist legacy lives on at Planned Parenthood

by Abby Johnson

| May 15, 2021 12:00 AM

Everyone in the pro-life community has known for decades that Margaret Sanger was a racist. She believed in eugenics. She believed that only the "fit" should be breeding and that family size should be limited. Sanger particularly targeted the black population through her "Negro Project," calling African Americans "reckless breeders" and "human weeds."

I remember hearing these allegations when I worked at Planned Parenthood, and I remember the organization vehemently denying them, pivoting back to its standard talking point about Sanger and how she was a "champion for women." In fact, according to Planned Parenthood, we owed all our feminine freedoms to Margaret Sanger. She was a modern-day hero. Pictures of her were hung on our walls, awards were given in her name, buildings were named after her, textbooks talked about how she helped to shape women's rights; I would venture to say that a few people probably named their children after her.

A couple years ago, I was on a call with an abortion rights group. Someone began talking about Sanger, and the question was posed, "Was she a racist?" The moderators began to chuckle and stated, "Well, she was a 'little r' racist. I mean, everyone was racist back then, so she just sort of fit into the mainstream crowd." I'm still not sure what a "little r" racist is. As far as I know, a racist is simply a racist, but I couldn't believe that these white women on the call were making excuses for Sanger's racist behavior and that the women of color listening were accepting it and then laughing about it. Since when is racism a laughing matter? Well, I guess when you are making excuses for the blatant racism shown by Planned Parenthood's founder, it's hilarious.

About a year ago, a group of 300 former Planned Parenthood employees wrote an open letter discussing the racism they witnessed inside of their recent employer. I was familiar with the racism they discussed. I remember co-workers giving bigger discounts to minority clients who came in for abortion services, reasoning that we couldn't have "those" women having too many kids. This is why 79% of Planned Parenthood abortion facilities are in nonwhite neighborhoods. As its founder said, we have to work hard to eradicate the "human weeds" in our society.

More than likely, you didn't hear much about that open letter from 300 former Planned Parenthood employees. The media did a fantastic job

of burying it and hiding it from the public. The liberal media's job is to protect the image of Planned Parenthood at all costs.

Now, after decades of denying Sanger's racist past and, in turn, its racist foundation, Planned Parenthood finally comes out and admits to it. Yes, she was kind of racist and dabbled in eugenic thinking, it says. And Planned Parenthood admits that is bad. But this is all a stunt. Please don't let it fool you.

If Planned Parenthood was really interested in undoing its racist roots, it would take a lot more than a media statement about its founder. If it were really serious about rebuilding a brand that was not riddled with racism, then it would immediately shut down the abortion clinics that it erected in black communities in order to intentionally snuff out black babies. It would invest in programs to actually help women of color. It would invest in fatherhood programs. It would help pay for women of color to get an education, including vocational training. It would offer comprehensive healthcare for men, women, and children. It would invest in safe housing options for minority families.

It would stop telling women that in order to succeed in life, you must kill your innocent child. It would instead empower women so that they didn't feel like they had to choose between their own success and the life of their child.

But you know what? Planned Parenthood will never do that. You know why? Because abortion pays too well. Investing in minority communities only costs them money. Abortion *makes* them money.

Planned Parenthood is the greatest predatory racist organization among us. It lies to, kills, and destroys the black community each and every day. Margaret Sanger told us exactly who she was, and people didn't believe it. Planned Parenthood tells us who it is by the communities it targets each and every day.

Abby Johnson is CEO and founder of And Then There Were None and author of Unplanned, *which was made into a feature film in 2019.*

A

Remove statues of Margaret Sanger, Planned Parenthood founder tied to eugenics and racism

How a woman who advocated for the selective breeding of her fellow citizens came to be memorialized with those who built a country is hard to understand.

Kristan Hawkins
Opinion contributor

All across America, video of activists attacking statues plays on a loop while some political leaders voice their support for removing all reminders of people whose personal histories put them in a negative light. In asking for the U.S. Capitol to be cleansed of Confederate statues, House Speaker Nancy Pelosi said they must go because their efforts were "to achieve such a plainly racist end." New York Gov. Andrew Cuomo said on NBC's "Today" show that removing statues is a "healthy expression" of priorities and values.

For those identifying historical figures with racist roots who should be removed from public view because of their evil histories, Planned Parenthood's founder, Margaret Sanger, must join that list. In promoting birth control, she advanced a controversial "Negro Project," wrote in her autobiography about speaking to a Ku Klux Klan group and advocated for a eugenics approach to breeding for "the gradual suppression, elimination and eventual extinction, of defective stocks — those human weeds which threaten the blooming of the finest flowers of American civilization."

Sanger's Planned Parenthood mission

In a 1939 letter to Dr. C. J. Gamble, Sanger urged him to get over his reluctance to hire "a full time Negro physician" as the "colored Negroes...can get closer to their own members and more or less lay their cards on the table which means their ignorance, superstitions and doubt."

Like the abortion lobby today, Sanger urged Dr. Gamble to enlist the help of spiritual leaders to justify their deadly work, writing, "We do not want word to go out that we want to exterminate the Negro population, and the minister is the man who can straighten out that idea if it ever occurs to any of their more rebellious members."

And that spirit of racism continues today, as more than 300 former and current employees of Planned Parenthood said recently in an open letter, noting a "toxic" environment.

"Planned Parenthood was founded by a racist, white woman. That is a part of history that cannot be changed," they observed, writing that the pattern of "systemic racism, pay inequity, and lack of upward mobility for Black staff" continues.

Margaret Sanger in Washington, D.C., on March 1, 1934.

Cultural icon Kanye West has made headlines with his recent statements on Planned Parenthood abortion vendors, which he said

have "been placed inside cities by white supremacists to do the Devil's work." He's right about the locations of the businesses.

The vast majority of the abortion vendors have set up shop in minority neighborhoods, which can be seen in the scarce statistics available at the Centers for Disease Control and Prevention. Though they are only 13% of the female population, African Americans made up 38% of all abortions tracked in 2016.

In the 1970s, when the Supreme Court's Roe V. Wade decision legalized abortion, polling showed that Blacks were "significantly less likely to favor abortion" than whites. Yet in New York City, more black babies are aborted than born alive each year. And the abortion industry think tank, the Guttmacher Institute, notes that "the abortion rate for black women is almost five times that for white women."

It would seem that Sanger's vision of ending Black lives has come to pass, though to be accurate she also endorsed ending Chinese preborn life as well.

Among those who advocate for the removal of statutes, signs and traces of racist ancestors there is no balancing of good and bad deeds. It would be hypocritical to say that the racist attitudes and eugenics policy preferences of Sanger should be ignored because it was a "tactic" to advance birth control that some consider a social good, the position of famed feminist Gloria Steinem.

Birth control to eliminate the 'unfit'

But consider Sanger's own words. In an article titled "A Better Race Through Birth Control," she wrote, "Given Birth Control, the unfit will voluntarily eliminate their kind."

"Birth Control does not mean contraception indiscriminately practised," Sanger wrote. "It means the release and cultivation of the better elements in our society."

Just this week, Planned Parenthood of Greater New York announced it will remove Sanger's name from its Manhattan abortion vendor location because of her "harmful connections to the eugenics movement."

Why stop there?

Sanger is honored in the Smithsonian's National Portrait Gallery and at Margaret Sanger Square in Manhattan. And a Margaret Sanger statue stands in the Old South Meeting House in Boston, which ironically enough is on the Freedom Trail commemorating the Revolutionary War. How a woman who advocated for the selective breeding of her fellow citizens came to be memorialized with those who built a country is hard to understand and a mistake easy to address.

While there are other places celebrating her, these three are a good place to start.They should not be removed through mob violence, but rather through the use of democratic tools, as a Students for Life group at the University of Missouri did in successfully petitioning for posters of Sanger to be removed.

Students for Life of America is launching an SOS: Strike Out Sanger campaign calling on pro-life people nationwide to demand the removal of Sanger's statues and symbols, which represent a racist who actively targeted minority communities because she did not value their lives. The founder of Planned Parenthood does not represent our American ideals, and her images and honors should be pulled down to gather dust in history's closet.

Kristan Hawkins is president of Students for Life of America. Follow her on Twitter: @KristanHawkins, or subscribe to her podcast, Explicitly Pro-Life.

Chair NADLER. The gentleman yields back.

Mr. Raskin?

Mr. RASKIN. Thank you, Mr. Chair. I appreciate it. I am hoping that I could use my few minutes here to cut through the thick fog of political rhetoric we have been hearing to try to identify what is really at stake in the discussion right now. I want to thank our GOP colleagues for inviting Ms. Foster to come in to testify because her testimony was [audio malfunction] of this Committee is at this point in the debate.

[Audio malfunction] with her husband, her partner, her physician, her family she can make the decision that she needs originally according to a trimester framework, but then for an abortion in the event of—that the abortion takes place pre-viability; that is, before a fetus could live outside the body of the mother. That is the Supreme Court's jurisprudence today and that is where we are in America.

I think it corresponds to the views of the vast majority of the American people that within the early period where you have a nonviable fetus that it is within the woman's right to choose under substantive due process liberty. It is part of the freedom of Americans to make that decision.

Now, Ms. Foster referred to abortions as murder of children and the murder of 20 million. I think we just heard from our distinguished colleague from Louisiana it is 22 million people who were killed, or children who were killed. She referred to it as a genocide. So, I want to be clear—

Mr. JOHNSON of Louisiana. Sixty-two million.

Mr. RASKIN. I am sorry. Sixty-two million. Okay. So, it is 10 times—and I have heard this also in anti-abortion rhetoric, 10 times the Holocaust that took place in Europe against the Jews. Sixty-two million, what she described as our fellow human beings and children have been killed through abortion. Okay?

I appreciate the moral clarity of her position. She says that under the Declaration; and we just heard another colleague invoke the Declaration, and of the Constitution that a fetus is a person within the meaning of Fifth Amendment and 14th Amendment due process. I confirmed that with her right after her testimony. She is from Maryland. I said, I just wanted to make sure that it is your position that a fetus is a person within the meaning of the Constitution. She said absolutely.

Now, the reason this is so important is this: We have seen what the Texas law, which of course bans abortion in the vast majority of cases—it bans it for cases of rape, and she was very enthusiastic and proud of that fact. It bans in the case of incest, and it converts everything into this system of bounty hunting where people are essentially turned into vigilantes, and they can go and sue a doctor, nurse, or family Members who help a woman exercise her constitutional rights.

So, what has happened in Texas, of course, is that people are flowing to Oklahoma, or they are going to Louisiana, or they are going to other parts of the country where they can get an abortion. I think some people feel well, that is okay. You will have this sort of checkerboard thing. Some States that will be like the Handmaid's Tale, but you will be able to flee to another State.

If you listen to what Ms. Foster is saying and what a number of our colleagues are saying today is they want a situation where abortion at any point is considered murder under the Constitution of the United States. So, if you follow the logic of her argument, abortion could not be allowed in any case, in any State for rape or incest, or anything else because it would be like allowing a State government to permit the mass murder of a subpart of the population.

I appreciate the honesty of that view. It is an extremist view, way outside of where the vast majority of the American people are. If you listen to the rhetoric of our colleagues, if you listen to the rhetoric of Ms. Foster, all of them seem to be saying that a fetus is a person within the meaning of our Constitution. Not only is it okay for Texas essentially to make it impossible for a woman to get an abortion, which is why they are all trying to get out on the Greyhound buses or whatever to Louisiana, Oklahoma, or California, but in every State it should be banned. If they do not believe that, then I think they should explain why they think it is okay for abortion to take place in some States and it is not murder, but in other States it is. If some of them are saying what certain people are saying, just let the States decide, I would like them to announce that they think it should be a right in the States that want to make it a right. It sounds to me like the new position of the Republican Party is that we should have a blanket ban on abortion across the land it is murder everywhere. That is the logic of the moral and constitutional position that they have advanced today.

If I have got—

Chair NADLER. The gentleman's time is expired.

Mr. Roy?

Mr. ROY. I thank the Chair.

The one word that has been consistently missing from my colleagues on the other side of the aisle today is heartbeat, because my colleagues on the other side of the aisle do not want to start with the concept of heartbeat. That is what this law is titled. That is what drove and motivated the people of Texas was to protect life when there was a heartbeat that was able to be identified.

Every one of us in this room has a heartbeat. Every one of us knows the tie of a heartbeat to life. That is what is at the center of this whole conversation, but my colleagues on the other side of the aisle do not want to start with that.

If you look at—listen to what my colleague from Maryland just said, when he was starting from the proposition of what it means in terms of banning certain abortions at certain times or, as he was saying, a national ban, as he was hypothesizing. He is starting from the premise not from the starting place of life and trying to defend life, but from the standpoint of law with respect to our current abortion law. That is because my colleagues do not want to start with the concept of life because it is a messy business.

As my colleague from Texas Mr. Gohmert described earlier, it is a messy business. There has been a lot of misinformation floating around about the Texas bill, right, saying that it is a flat-out ban on abortion, yet there have been still 2,000-plus abortions in September after the law took effect. I do not think we have the data

for October, yet. Two thousand-plus abortions. Now, I will acknowledge that it is an over a 50-percent drop from the five-thousand-and-something abortions in August.

The question I was going to ask of our Witness, who obviously is no longer here because we did not meet for two hours this morning, and now we are meeting at night and she was not able to be here—but what I was going to ask her is what conversation would she like to have with the 2,000–3,000 lives that will be walking this planet in September alone, the 2,000–3,000 lives that will be walking this planet because of this bill?

Now, I know my opponents on the other side of the aisle want to fixate on *Roe* or *Casey*. That is fine. We can have those legal debates. What we are talking about here are human beings and life. That is what is at the center of all this. The question becomes—and as my learned friend from Maryland talked about, he said the vast majority of—I think—the exact phrasing, but a nonviable fetus in the first trimester in the context of abortion law. Okay? Texans decided through their elected body in the State legislature to say that if there is a heartbeat detected, that life should be protected. That is what the people of Texas decided.

Then, I hear all this sort of wailing and gnashing of teeth about the construct of the law, about how it is novel, yet this construct is very similar, for example, to a State law, say Colorado, telling a cake baker to bake a cake under Colorado law despite conflicting with a deeply-held religious belief of the baker, and then forcing the cake baker to decide whether to proceed in the face of possible private litigation, challenging his or her decision, and whatever that means in terms of cost and impact, and then find a way to litigate his or her First Amendment rights in State or Federal court. We act like this is some sort of novel concept, but it is not. This is a debate. This is the kind of thing you litigate, but you have got people in Texas saying hey, we think life is worth protecting.

I would note, as I said before, that there were 2,000 abortions in September. In Texas in 2020, 49,000, almost 49,000 of the 54,000 roughly; I am rounding, abortions were less than 10 weeks. What we are talking about here is saying that if there is a heartbeat, that we do everything we can to protect that living being.

When you talk about vigilante justice, what we are talking about is the ability to go bring suit in defense of a life. That is what we are talking about. Nothing more; nothing less. It is everything.

Again, I would reiterate, my colleagues on the other side of the aisle will not want to, have not wanted to talk about the heartbeat because they know it undermines their position. I yield back.

Chair NADLER. The gentleman yields back.

Ms. Jayapal?

Ms. JAYAPAL. Thank you, Mr. Chair.

I think some of you know that I am one of the one in four women in America who has had an abortion. I testified about that recently. I first told my story two years ago when this rash of bills was starting to come up, and I told it after more than a decade. I actually had not even told my mother about it before I wrote an op-ed in the paper. For me it was actually a very difficult decision to make. It is not for everybody, and I do not think it should have to be.

So, Mr. Roy, you are right. We have different starting places. I start with the Constitution. I start with the Constitution, and I start with the Constitutional right that I have to make choices about my own body. I, also, am very offended by the idea that anybody on your side would call me a murderer for making a choice about my health and my body that you cannot even begin to understand or know what I was dealing with. So, please do not be paternalistic towards us as we make choices that are our choices.

Nobody knows the circumstances we go through. Nobody understands what we have to think about. By the way, nobody except us is actually—the pregnant person is actually the person that is affected along with anybody that we choose to bring in. You know what, I would like to leave protecting my health to my doctor and to me. I do not think that Ms. Piñeiro, or I, or any other person who makes this constitutionally-protected choice should be traumatized by being called a murderer. That is just outrageous in my mind.

Professor Bridges, in your testimony and your answers to my colleagues you have spoken about the intersections of abortion, race, and poverty and how bans on the Constitutional right to abortion disproportionately affect women of color. Are these intersections part of the reason a pregnant person's Constitutional right to an abortion is treated as different and inferior to other Constitutional rights?

Dr. BRIDGES. Absolutely. We live in a country of abortion exceptionalism where the fundamental right to terminate a pregnancy before viability is treated dramatically differently than the other fundamental rights that are found in the Constitution. The most glaring example of that, that abortion rights are treated differently, is the fact that SB 8 is in effect right now. The Supreme Court let a flagrantly unconstitutional law go into effect and two months later we're still dealing with the fallout from that.

Ms. JAYAPAL. Ms. Piñeiro, thank you for your testimony. Thank you for being here. I think it is probably impossibly difficult to listen to what has been said today, and I thank you for your courage and for your grace.

Another issue that often overlaps with reproductive justice is health coverage. You highlighted in your powerful testimony that, because of the Hyde Amendment, your abortion care was not covered. Thinking about the patients that your fund serves and your personal experience, how are communities of color, in particular, disproportionately impacted by restrictions on abortion funding by health insurance programs such as Medicaid?

Ms. PIÑEIRO. Thank you for your question, Congresswoman, and I appreciate the solidarity here. It is not easy to hear the inflammatory rhetoric. As a survivor, as someone who has had an abortion here, I am consistently offended.

This is not new. This is what people who have abortions deal with. This is what, quote "sidewalk counselors" unquote, are yelling at patients who are going in to get healthcare.

Just on the Hyde Amendment, I think it's ironic that we spent the day talking about abortion restrictions alleging supporting women and their families. If we were to end the Hyde Amendment, I would hope that a priority could be to fund programs for women

and their families, so that clients like the ones I see don't have to choose between feeding their family and having an abortion.

Ms. JAYAPAL. Thank you, Ms. Piñeiro.

Dr. Moayedi, as an abortion provider in Texas, you see firsthand the medical harms of these abortion bans. What new challenges will patients and providers face now that Texas has authorized private people to become vigilantes and patrol reproductive healthcare?

Dr. MOAYEDI. Well, I'm seeing it right now. We have people that are critically ill and pregnant and need an abortion to save their life, and we are having delayed care. We are going to see a dramatic increase in maternal mortality in our State, as people are forced to continue pregnancy. We know that pregnancy is at least 10 times—childbirth is at least 10 times more dangerous than abortion care, and you are more likely to die. That is even more true in Texas with our maternal morbidity and mortality rate. So, I am already seeing the devastating effects in my community, and I expect that this will be getting worse.

Ms. JAYAPAL. Thank you.

Mr. Chair, I just would ask that my colleagues stop calling us murderers. I do not appreciate that.

I yield back.

Chair NADLER. I agree with you.

The gentlelady yields back.

Mr. Bishop?

Mr. BISHOP. Thank you, Mr. Chair.

This is a most extraordinary hearing about something that it is unclear to me why this body, this Committee, is taking it up. It seems inappropriate in the week that the United States Supreme Court is undertaking solemn judicial, independent consideration of the law in Texas.

I think I can't fail to comment on one aspect of where we are. I would submit that there are two reasons that Texas' Senate Bill 8 is so impactful, unusually impactful. First, is that the exercise of the right to abortion depends upon at all times a huge moneymaking industry carrying it out that will put its financial interests first. Second, that industry knows that it can never rest secure in the proclamation of a right to kill another utterly innocent human being. It is simply an untenable claim. It is as untenable as when the Supreme Court of the United States in *Scott* v. *Sandford* that freed slaves of African heritage could not become citizens of the United States or enjoy the rights, privileges, and immunities thereof.

It will never be a settled issue until the humanity of the unborn child is recognized and protected. This is a picture of a child 12-weeks gestation. Her fist is clenched. It is a little girl. It is not just some anonymous picture. She now is a thriving child. Her hand and arm is visible. She is a human. She cannot be disregarded. It is not possible for us to pretend that she does not exist. She exists.

Dred Scott was settled law at one point, and it awaited the turn of history for that to be vindicated. That is exactly the situation here.

I yield back.

Chair NADLER. The gentleman yields back.

Ms. Demings?

Ms. DEMINGS. Thank you so much, Mr. Chair.

First, as a Member from Florida, Ms. Piñeiro, I want to thank you so much—first, welcome to this hearing—but, also, I thank you so much for your testimony today. People may think they know your story, but today you have been able to tell it. They may not care about your story, but I care. I thank you for being an advocate on behalf of women and girls around this nation.

I spent 27 years in law enforcement, and I want to talk about constitutional rights. Today, I not only speak as a Member of Congress, I also want to speak as a police officer, as a police chief.

As an enforcer of the law, I took an oath that I would protect and defend the Constitution of the United States. In my law enforcement career, you can imagine I have seen and experienced much—the joys and pains of life. I have worked rallies and demonstrations by the Ku Klux Klan, the Neo-Nazis, and other extremist groups. I have heard names and been called names, like coon, savage, and I've heard the "N" word more times than I care to acknowledge.

As these extremists hurled their racial slurs and insults, as I worked the rally to provide security for them, as a law enforcement officer who remembered the oath that I took, I would have risked my life to stop anyone who tried to do them harm. Of course, I did not agree with what they were saying or why they were demonstrating, but I took an oath to protect their right to say it and to demonstrate.

The United States Constitution is a stubborn document. Rights are stubborn, too, even the rights of women. *Roe* v. *Wade* is clearly established and well-settled law, and its violation is blatantly unconstitutional.

I have also, as I end my remarks—I don't have any questions today—but, I have also worked and seen, as a law enforcement officer, the threats and harassment of women and teenage girls and providers. We have certainly had to work cases of providers who gave their lives as they were trying to provide the service.

So, I don't know how much longer this debate is going to go on, but we live in the United States of America. The supreme law of the land is the U.S. Constitution. As long as I am here, I will continue to protect and defend it.

Thank you, Mr. Chair, and I yield back.

Chair NADLER. The gentlelady yields back.

Ms. Spartz?

Ms. SPARTZ. Thank you, Mr. Chair.

Interesting to me how far we are drifting apart. As my colleagues, and my Democratic colleagues used to say, abortion should be rare; supported the Hyde Amendment on a bipartisan basis, but take very more extreme pro-abortion ideologies, and we can see it in some of the laws like the State of New York.

I wanted to share just a little bit. I have a unique experience. I grew up in the Soviet Union. Actually, the Soviet Union was the first country in Europe that in the 1920s legalized abortion under Lenin, and it was a country where life didn't matter; individual life didn't matter. It was all collective, all for them, collective responsibility. Everything is just collective as a group, not as individuals.

So, when I came here, I was very inspired and impressed by such an intrinsically valuable value of human life that is really embedded, including in our fine documents. Our Declaration of Independence talks about God-given rights, and rights to life is the first one and it is the most important, where you matter as an individual. It is very deep with the respect for life, all rights to life for born and unborn. It is so American, and I just very differentiate it from a lot of other countries around the world.

Since we don't have a Witness—I just generally was very surprised at the timing of this hearing. I might just ask, since we have another scholar, Ms. Bridges, here. So, as a scholar, you point out, actually, in your testimony that Texas law disproportionately impacts Black women, women of color. If we are going to talk about racial injustice and Black Lives Matter/All Lives Matter, then it seems like some issues of this bill are not only for the community, but this I'm not going to ask you because you and I have different disagreements on that, and we will never agree.

My question would be for you, we have a State legislature that has an ability to regulate abortions. We have a Supreme Court that can rule on that and can decide if something is unconstitutional. We actually have three cases that the Supreme Court is going to review. One of them just was heard on Monday.

So, is it in your views or there any reason why this body should hold this hearing for any reason than just exert improper political influence over an independent branch of government, our Judicial branch? So, I would have a question for you. Do you see any reason why we should be even doing it right at this moment?

Dr. BRIDGES. Yeah. Thank you for your question. I really appreciate it.

First, it's Professor Bridges or Dr. Bridges.

Second, you said that State legislatures have enacted this law; this is a democratically elected law. I think we should drop a footnote next to that because it is unclear whether this is a democratically elected law. Texas has the most restrictive, one of the most restrictive voting rights, voting regulations. So, I would be skeptical that all the people were represented in this law.

Third, you're absolutely right that the judiciary is called upon to interpret the Constitution and protect rights. We are here today—thank you for asking that question—we are here today because the judiciary did not do that. The judiciary did not follow its own established precedents. Its own established precedents would have led it to enjoin a flagrantly unconstitutional law. It did not do that. In fact, its own established precedence would lead it to preserve the status quo. It did not do that. Its own established precedence—

Ms. SPARTZ. I think that—yes, I don't think this was a precedent.

Dr. BRIDGES. Its own established precedence—

Ms. SPARTZ. Yes, because, actually, they are reviewing the procedure and they are going to rule on the procedures.

Dr. BRIDGES. Its own established precedence—absolutely.

Ms. SPARTZ. They have three cases right now. They are going to look at the procedures of the law, because it was, actually—there is not much precedent. It was very different law. The Supreme Court two cases to look at Texas, and it has a Mississippi case. There are a whole lot of cases in the Supreme Court. So, why we

should be discussing this now? Is there any reason you see to discuss it now, except to influence the decision of the Judicial branch, which is an independent branch and equal to us?

Dr. BRIDGES. We should be talking about this case because procedural rules have substantive consequences.

Ms. SPARTZ. All right. They didn't rule on that.

Dr. BRIDGES. Second, the concept—

Ms. SPARTZ. That is what the problem is. They just convened that, right?

Dr. BRIDGES. The mere failure to rule on the procedure—

Ms. SPARTZ. They are going to have two cases. They are going to rule on procedures. Two cases they are going to decide. They just had arguments on Monday.

Dr. BRIDGES. In the meantime, the rights of Texans are being infringed. A flagrantly unconstitutional law is in effect.

Ms. SPARTZ. The Court hasn't made any decisions.

So, I yield back.

Chair NADLER. The time of the gentlelady has expired.

Ms. Scanlon?

Ms. SCANLON. Thank you, Mr. Chair.

It is rather bizarre that at this late date, 40-some-odd years after *Roe* v. *Wade* that we have to have a hearing on this, and that the harmful effects of SB 8 have almost immediately manifested themselves in completely halting access to abortion for women in Texas who are not like wealthy or connected.

It has also burdened the reproductive healthcare systems of other States that have chosen not to violate the Constitution. In doing so, this law has created a framework that deliberately seeks to violate a women's constitutional freedom to decide when and whether to become a parent, based on her own unique circumstances.

SB 8 does so by creating a tortured legal fiction to avoid judicial review, and in the process, threatens other constitutional rights. Just as a baseline, the decision to have an abortion is deeply personal. We, as legislators, must ensure that anyone who becomes pregnant can access a full range of safe medical care, free from fear, coercion, or lawmakers who want to insert themselves into a medical practice.

We have heard several stories of why people may choose to access abortion care. In my professional life, I have had two clients who faced the choice of whether to carry a pregnancy to term or not. Both were young women who had a first child when they were in their teens and had suffered abuse at the hands of family Members. They struggled to keep themselves and their children housed and fed, and when they were victimized by much older men, became pregnant again. They each had their own personal reasons for choosing not to have another child, including compelling medical, financial, and emotional reasons.

One lived in Pennsylvania and was able to make the best decision for her circumstances. She chose not to have another child at that time, and as a result, was able to leave the abusive relationship which had caused the pregnancy, finish school, get a good job, marry, and have two more children with her husband.

The other lived in Texas, and this was before SB 8 took effect, but not before the State had imposed some of the most restrictive anti-abortion laws in the country. She couldn't afford to travel or pay for an abortion, and she was forced to bear a child, although she and the child suffered preventable physical injury and great economic harm.

So, these are just two of the stories. We have heard other stories. It pains me that we need to share personal stories with private reasons to demonstrate the endless array of reasons why someone might choose not to avail themselves of having another child. These stories shouldn't have to be told over and over again.

Professor Bridges, I just wanted to dig a little bit into some of the legal basis for this crazy SB 8 law. So, as I understand it, the Texas legislature has decided to make having an abortion illegal in Texas but has outsourced enforcement of that from the State to private citizens who can sue anyone who has an abortion or helps someone to have an abortion, and get $10,000 from them.

This seems really tortured, and it also seems to implicate other rights. So, for example, if we were to have a State that decided to outlaw evangelical Christians—I think practicing your First Amendment religious rights is a pretty clear constitutional rule. So, if the State of Georgia, say, said no more evangelical Christians; it is illegal to practice that religion in the State of Georgia, and the State is not going to do anything about it, but anyone anywhere—it doesn't matter if you are in Georgia or anywhere else—you can sue anyone who is a practicing Christian in Georgia for a million dollars. Isn't that what this law is trying to do in Texas, and what is the problem with that?

Dr. BRIDGES. Absolutely. So, we're here today because the Supreme Court has allowed Texas to offer all the States a blueprint for violating constitutional rights. No constitutional right is safe. This begins at abortion, but who knows where it will end? The First Amendment free exercise right; the 14th Amendment right to same sex marriage; the 14th Amendment right to consensual sexual contact; the Second Amendment right to bear arms—no constitutional right is safe, and that is why we're here today.

Ms. SCANLON. Thank you.

I think the very structure of this law should give people pause and be more than solid grounds for why it should never have taken effect, should not be a model for other states, and should be promptly overturned.

Thank you. I yield back.

Chair NADLER. The gentlelady yields back.

Mr. Bentz?

Mr. BENTZ. Thank you, Mr. Chair.

I join Mr. Roy, Mr. Johnson of Louisiana, and Ranking Member Jordan in expressing my regret that Ms. Foster is not here to elaborate upon her remarks regarding additional options for women who find themselves with an unplanned pregnancy. I regret that she is not here to speak to the offerings of the thousands of resource centers across this United States. I regret that she is not here to further elaborate and emphasize that life is not frivolous. She is not here.

So, with that, Mr. Chair, I yield the balance of my time to Mr. Johnson from Louisiana.

Mr. JOHNSON of Louisiana. I thank the gentleman from Oregon.

Ms. Piñeiro, you are a board member of the Central Florida Women's Emergency Fund, which strongly supports legalized abortion, right?

Ms. PIÑEIRO. That is incorrect.

Mr. JOHNSON of Louisiana. Okay. What does that organization do?

Ms. PIÑEIRO. I'm the Co-Executive Director of Florida Access Network.

Mr. JOHNSON of Louisiana. Okay. Well, our hearing outline said other. So, the Action Network strongly supports legalized abortion, right?

Ms. PIÑEIRO. Correct.

Mr. JOHNSON of Louisiana. Help me understand the position of your organization. These are simple yes-or-no questions.

Is it okay to murder a 10-year-old child?

Ms. PIÑEIRO. No one should be forced to remain pregnant if they don't want to.

Mr. JOHNSON of Louisiana. Is it okay to murder a 10-year-old child, yes or no?

Ms. PIÑEIRO. I am deeply offended that you would call me a murderer.

Mr. JOHNSON of Louisiana. I'm not calling you a murderer, ma'am. I'm asking you a question. Is it okay to murder a 10-year-old child? This is about your organization's position. Would they say yes or no?

Ms. PIÑEIRO. My organization's position is that no one should be forced to remain pregnant if they don't want to. Any abortion restrictions are—

Mr. JOHNSON of Louisiana. Okay, okay. Let me answer the question for you. I'm assuming that you do not advocate for the murder of children. Okay. What about a toddler? I assume you would say it is not okay to murder a toddler, either, a 2-year-old. What about a newborn. Let me ask you this: Is it the position of the organization, are you for partial birth abortion? Is that the position of the organization? Would you support that?

Ms. PIÑEIRO. What my organization is for is to support the people who need abortion care who are lied to when they are sent to alleged pregnancy resource centers that lie to the patients—

Mr. JOHNSON of Louisiana. Okay. Would that—excuse me just a second. Just a second. Would that apply—

Ms. PIÑEIRO. —and tell them—

Mr. JOHNSON of Louisiana. Would that apply to a woman who is nine months pregnant?

Ms. PIÑEIRO. I disagree with the premise of your question.

Mr. JOHNSON of Louisiana. Would you support the abortion of a late-term unborn child?

Ms. PIÑEIRO. Anybody should have, should have the right to have an abortion at any time for any reason.

Mr. JOHNSON of Louisiana. Anytime? Okay. That's what I need. So, here's the thing. I'm just trying to understand the logical fallacy. So, if we would not support—and I mean this sincerely and

this is not for you personally; I'm talking about the organization. You support an advocacy organization.

If it is not okay to take the life of a small child outside the womb, why is it okay to take the life of a small child nine inches up the birth canal inside the womb? What is the distinction? Help me understand the distinction of that.

Ms. PIÑEIRO. I don't understand the question.

Mr. JOHNSON of Louisiana. You would not support the murder of a small child, right? No one would. No civilized person would. Why do we support the taking of a life of a child right before they are delivered?

Ms. PIÑEIRO. No civilized person should support forced pregnancy.

Mr. JOHNSON of Louisiana. Does abortion take the life of something that is alive?

Ms. PIÑEIRO. No one should be forced to remain pregnant against their will.

Mr. JOHNSON of Louisiana. Ma'am, you are not answering my questions.

Let me ask the doctor on this screen. Is it okay—or let me ask you this: Does abortion kill something that is alive, take the life of something that is alive?

Dr. MOAYEDI. Sir, the way that you are asking these questions actually intentionally invite violence and harassment to both of us, to all of us.

Mr. JOHNSON of Louisiana. I'm sorry, that is an absurd response. You are a medical doctor. Tell me if there is an unborn child in the womb or not. Are we killing something that is alive? When you dismember something in the womb, is that a human being or not? It is living being, yes or no?

Dr. MOAYEDI. I am here to talk about medical care.

Mr. JOHNSON of Louisiana. Yes, this is a direct question about medical care, ma'am. You positioned yourself as an expert on the issue. Are we taking a life or not? Is it a life, yes or no?

Dr. MOAYEDI. What you are discussing is not the reality of how abortion care is delivered in this country.

Mr. JOHNSON of Louisiana. If we were in a courtroom, I would say that is nonresponsive. I think we all know why you don't want to respond to that, because the obvious fact here is that you are taking a human life. It is a small human life. It is a human being.

Let me ask you, Doctor, should abortion be allowed because of the sex of the pre-born child, in your medical opinion?

Dr. MOAYEDI. I do not believe that there should be any restrictions on the bodily autonomy of—

Mr. JOHNSON of Louisiana. Okay. All right. Hold on. So, if someone gets a pregnancy test and they say it is a little girl, and I want a little boy, it is okay to abort that child?

Dr. MOAYEDI. I have never seen a pregnancy test that tells you the sex.

Mr. JOHNSON of Louisiana. Would it be okay or not?

Dr. MOAYEDI. I have never—

Mr. JOHNSON of Louisiana. If someone has an ultrasound and they know they have one sex and they want to abort it, is that okay?

Chair NADLER. The time of the gentleman has expired.

Ms. Garcia?

Mr. JOHNSON of Louisiana. I will just note that no one answered the questions.

Thank you. I yield back.

Chair NADLER. Ms. Garcia?

Ms. GARCIA. Thank you, Mr. Chair.

Thank you to all the Witnesses here today. I know that it has been a long day and thank you for your patience and thank you for allowing yourselves to be questioned by all of us.

Especially to you, Ms. Piñeiro, for just sharing your deeply personal story. I know it still breaks your heart to have gone through both of those abortions and the reasons that you had to. So, thank you for sharing.

Women's freedom to choose is under attack in our country. Simply put, politicians and the government have no place controlling women's freedom to choose their reproductive care. They should not be in the business of controlling women's bodies, period.

The Texas law—and just for the record, I am a native Texas, and I am also Catholic—the Texas law has already had devastating effects on Texas women, especially women with low income, Black and Latino women suffering the most. Many have crossed State lines to access abortion. In a sense, some of these women are fortunate because they have the resources and the logistical knowhow to seek an abortion outside of Texas.

Consider, for instance, a woman living in my district who would have to drive 10 hours to get to a State where she could access reproductive healthcare. She would have to make the drive alone or risk a loved one being sued for helping her.

According to a filed amicus brief by Planned Parenthood with the U.S. Circuit of Appeals for the 5th Circuit, one woman said she is concerned with taking time off work to travel for the abortion because it could affect her job. She said she struggles to cover expenses and lives paycheck to paycheck. She considered using a ride service taxi, but the idea is scary because she knows she would be in a car alone with a stranger, as she is coming off anesthesia. This is appalling that women have to have these considerations.

In South Texas, where I grew up, many Latinas and immigrants already fear deportation and face huge barriers to abortion due to long distance and travel restrictions. Another woman in Houston who only speaks Spanish shared her concern that she had not been to another State and could not understand why, still cannot understand why, they have to leave Texas for an abortion or what would be required when they get to another State. This is heartbreaking.

Just a few weeks ago, I visited my local Planned Parenthood health center and heard countless other stories about Texas women who are resorting to self-help, including drinking abortion tea that they found on the internet. Dare we say that many of these results, may end up in backroom-alley abortions and maybe even the use of hangers, as we saw in the past.

This is totally unacceptable. We trust women to know what they need and how they come to this decision with their families, their faith, and their future in mind and Americans agree.

Mr. Chair, I have an exhibit here that I ask unanimous consent to be entered into the record.

Chair NADLER. Without objection.

[The information follows:]

MS. GARCIA FOR THE RECORD

GALLUP®

JUNE 9, 2021

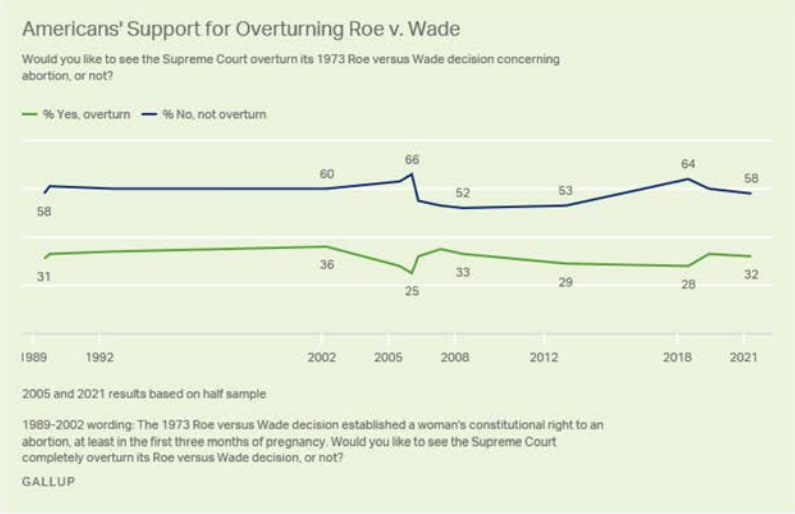
Americans Still Oppose Overturning *Roe v. Wade*

BY **LYDIA SAAD**

STORY HIGHLIGHTS

- Nearly six in 10 Americans do not want Roe v. Wade overturned
- Republicans are closely split on reversing the landmark decision
- Bans on early-term abortions fall short of U.S. public support

WASHINGTON, D.C. -- Gallup's latest update on U.S. abortion attitudes finds 58% of Americans opposed to overturning the U.S. Supreme Court's 1973 *Roe v. Wade* decision, while 32% are in favor. Since 1989, between 52% and 66% of U.S. adults have wanted to maintain the landmark abortion decision. Today's support roughly matches the average over that three-decade period.



The high court recently announced it will take up a Mississippi law prohibiting abortion after 15 weeks of pregnancy, throwing into question the future of *Roe* as the standard for reviewing abortion bans. *Roe* specifies that states may *regulate* abortion before fetal viability in the interests of maternal health, but not ban the procedure before that developmental stage. *Roe* established a guideline of 24 to 28 weeks for fetal viability.

Several other Republican-led states have passed restrictions on abortion designed to test the Supreme Court's support for *Roe*, should those laws ever reach the high court, as the Mississippi law has. Gallup tested three of these in the May 3-18 poll.

The new poll can't evaluate state residents' support for their own state's abortion laws. However, consistent with their opposition to overturning *Roe*, majorities of Americans overall oppose two specific prohibitions on abortion at early stages of fetal development.

- Fifty-six percent are opposed to banning abortions after the 18th week of pregnancy, a threshold used in laws passed in two states (Arkansas and Utah), although both laws are currently blocked by court orders.
- Fifty-eight percent oppose banning abortions once the heartbeat of a fetus can be detected -- an abortion restriction passed in several Republican-led states, all of which face court challenges. A fetal heartbeat can typically be detected between six and eight weeks into a pregnancy. While that time frame wasn't specified in the latest Gallup measure, it was in a 2019 question, with similar results.

Additionally, the poll finds a majority of Americans -- 57% -- opposed to generally banning abortion if performed because the fetus is found to have a genetic disease or disorder. Arizona's governor recently signed such a bill into law, outlawing abortions conducted exclusively because of nonlethal genetic conditions such as Down syndrome and cystic fibrosis.

Americans' Support for Restrictions on Abortion Based on Fetal Development

Do you favor or oppose each of the following restrictions on abortion?

	Favor	Oppose	No opinion
	%	%	%
A ban on abortions after the 18th week of a pregnancy	41	56	3

Results based on Form B half sample

GALLUP, MAY 3-18, 2021

	Favor	Oppose	No opinion
	%	%	%
A ban on abortions after a heartbeat can be detected in the fetus	38	58	4
A ban on abortions that are done if a fetus is found to have a genetic disease or disorder	38	57	4

Results based on Form B half sample

GALLUP, MAY 3-18, 2021

Previous Gallup polling on this topic found significant variation in support for abortion rights, depending on the type of disorder the child might be born with, as well as when those abortions would occur. At their most supportive, two-thirds of Americans favored abortion being legal in the first trimester when the child would be born with a life-threatening illness. The majority also favored legal abortion in first trimesters when the child would be born mentally disabled. Just shy of half (49%) favored abortion at this stage if the child would have Down syndrome. Support drops significantly for abortion in all three scenarios if each were to occur in the third trimester.

Gallup's broader question on the legality of abortion, updated in the latest poll, finds a third of Americans (32%) believing abortion should be legal in all circumstances and 48% favoring it being legal in certain circumstances, while 19% say it should be illegal in all circumstances.

Opposition to Early Abortion Bans Is Widespread

Public support for the specific abortion restrictions tested in the latest poll falls well short of majority level among most demographic subgroups across society, including by gender, age and race.

Support varies more substantially by political party, with Republicans (including independents who lean Republican) much more supportive of all three bans than Democrats and Democratic leaners. Even among Republicans, however, little more than half are in favor of prohibiting abortion after the 18th week (57%) or after a fetal heartbeat can be detected (54%). Just shy of half of Republicans (49%) would like to see laws banning abortion in the case of genetic disorders, while 48% would not.

On the question of *Roe v. Wade*, 46% of Republicans favor overturning it, while 43% are opposed.

Americans' Support for Abortion Law Changes, by Key Demographics

	Overturn *Roe v. Wade*	Ban after 18th week	Ban after fetal heartbeat detected	Ban for genetic disorders
	%	%	%	%
U.S. adults	32	41	38	38
Gender				
Men	30	37	39	38
Women	34	46	37	39
Age				
18 to 34	37	37	33	31
35 to 54	30	45	37	37
55 and older	32	41	41	46
Race				
White Americans	30	45	38	39
Non-White Americans	37	33	38	37
Party ID with leaners				
Republicans/Lean Rep.	46	57	54	49
Democrats/Lean Dem.	21	28	25	30

GALLUP, MAY 3-18, 2021

Naturally, support for overturning *Roe v. Wade* and for laws banning abortion in certain situations varies by whether respondents self-identify as "pro-choice" or "pro-life" in their abortion views. However, the correlations are by no means absolute.

Segments of pro-choice Americans support overturning *Roe* (16%) and implementing bans on abortions conducted after the 18th week (30%), after a fetal heartbeat is detected (21%) or in the case of genetic disorders (30%). Similarly, barely half of self-identified pro-life Americans favor some of these policies, while between 38% and 49% oppose them.

Americans' Support for Abortion Law Changes, by Position on Abortion

	"Pro-choice"	"Pro-life"
	%	%
Overturn *Roe v. Wade*		
Favor	16	51
Oppose	77	38
Ban after 18th week of pregnancy		
Favor	30	53
Oppose	67	46
Ban after fetal heartbeat detected		
Favor	21	55
Oppose	76	43
Ban for genetic disorders		
Favor	30	47
Oppose	66	49

Americans' abortion views based on respondents' answer to whether they consider themselves "pro-choice" or "pro-life" on abortion.

GALLUP, MAY 3-18, 2021

Bottom Line

"Overturning *Roe v. Wade*" is a shorthand way of saying the Supreme Court could decide abortion is not a constitutional right after all, thus giving control of abortion laws back to the states. This does not sit well with a majority of Americans or even a large

subset of Republicans. Not only do Americans oppose overturning *Roe* in principle, but they oppose laws limiting abortion in early stages of pregnancy that would have the same practical effect.

View complete question responses and trends (PDF download).

Learn more about how the Gallup Poll Social Series works.

SURVEY METHODS ⊕

RELEASE DATE: June 9, 2021
SOURCE: Gallup https://news.gallup.com/poll/350804/americans-opposed-overturning-roe-wade.aspx
CONTACT: Gallup World Headquarters, 901 F Street, Washington, D.C., 20001, U.S.A
+1 202.715.3030

Ms. GARCIA. It is the results of a Gallup poll which says Americans still oppose overturning *Roe* v. *Wade*. Nearly 6 in 10 Americans do not want *Roe* v. *Wade* overturned. Texans, too, agree.

Chair NADLER. Without objection.

Ms. GARCIA. A recent poll in April of 2021 says that a majority of Texans are against new abortion restrictions or oppose provisions in SB 8—again, a majority of Texans, April, just a few months ago.

So, the fact remains that this bill has had devastating effects on women and will continue to do that.

So, I want to start with the doctor. Again, thank you for going through all the other things that Texas does to restrict abortions.

Are you seeing more and more women going out of State, particularly minority women? Have you seen any impact or effects of any self-help that they may have done on their own?

Dr. MOAYEDI. I am. I travel to Oklahoma to provide abortion care as well. Prior to SB 8, maybe about 10–15 percent of my patients in Oklahoma would be from North Texas; last week, 80 percent—80 percent. Some as far as Galveston and Texas City drove to get to Oklahoma City. So, I'm already seeing the devastating effects.

Thankfully, we have options to self-manage abortion with mifepristone and misoprostol that can be safe, but the option is limited for many people.

Ms. GARCIA. Thank you. I see I just have eight seconds, and I wanted to ask you, Ms. Piñeiro, is there anything else you wanted to add about your experiences?

Ms. JACKSON LEE. [Presiding.] The gentlelady's time—the gentlelady's time has expired.

Ms. GARCIA. Thank you. I yield back.

Ms. JACKSON LEE. The gentleman from Utah is recognized, Mr. Owens.

Mr. OWENS. Thank you, Ms. Chair and Witnesses who are appearing before our Committee today.

I, first, want to take a moment to say that my constituents from Utah have some serious concerns about the Department of Justice suing Texas because the Biden Administration doesn't like one of its laws. Utah signed an amicus brief in *United States* v. *Texas*. I would like to request unanimous consent to enter that brief into the record.

Ms. JACKSON LEE. Without objection, so ordered.

[The information follows:]

MR. OWENS FOR THE RECORD

No. 21-588

IN THE
Supreme Court of the United States

UNITED STATES OF AMERICA,
Petitioner,
v.

STATE OF TEXAS, *ET AL.*,
Respondents.

On Writ of Certiorari Before Judgment to the United States Court of Appeals for the Fifth Circuit

BRIEF OF INDIANA, ALABAMA, ARIZONA, ARKANSAS, FLORIDA, GEORGIA, IDAHO, KANSAS, KENTUCKY, LOUISIANA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, OHIO, OKLAHOMA, SOUTH CAROLINA, SOUTH DAKOTA, UTAH, AND WEST VIRGINIA AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

May the United States bring suit in federal court and obtain injunctive or declaratory relief against the State, state court judges, state court clerks, other state officials, or all private parties to prohibit S.B. 8 from being enforced.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

CASES [CONT'D]

CASES [CONT'D]

STATUTES

INTEREST OF *AMICI* STATES

The States of Indiana, Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, Ohio, Oklahoma, South Carolina, South Dakota, Utah, and West Virginia respectfully submit this brief as *amici curiae* in support of Respondents.

In this case the federal Executive Branch has taken the remarkable position that it can go into federal court to seek an injunction against a State any time it thinks a state law violates someone's constitutional rights—or at least, it insists, it can do so whenever individuals would find it difficult to bring pre-enforcement challenges themselves in federal district court. This would permit the Executive Branch to challenge all manner of state laws, and *Amici* States submit this brief to explain why the Court should reject this position and should therefore reverse the district court's preliminary injunction.

SUMMARY OF THE ARGUMENT

The district court's order below threatens to expose every State in the Union to suit by the federal Executive Branch whenever the U.S. Attorney General deems a state law to violate some constitutional right of someone, somewhere. Critically, the district court enjoined everyone in the world from enforcing all of S.B. 8 *not* on the basis of any legal right the federal government *itself* holds, but on the ground the law violates the putative "Fourteenth Amendment substantive due process right[] to pre-viability abortions," App. 73a—which is, of course, a "'right of the *individual*.'" *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992) (quoting *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (emphasis in original)).

All agree that no statute provides the Attorney General a cause of action to seek such an injunction to enforce individuals' Fourteenth Amendment rights. It is thus clear that if he has authority to seek "the order he did, it must be found in some provisions of the Constitution." *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 587 (1952). Yet the district court made no effort to specify any constitutional provision granting such authority, but instead simply declared that "[n]o cause of action created by Congress is necessary," for in its view the federal Executive Branch has *inherent* power "to seek an injunction to protect . . . the fundamental rights of its citizens under the circumstances present here." App. 39a–40a.

1. Even the Attorney General, however, acknowledged in the district court below that for many years "courts have held that the mere fact that federal constitutional rights are being violated does not necessarily authorize the United States to sue." ECF 8 at 25–26. And both Congress and the Executive Branch have long shared the view that the Attorney General can bring suit only if *Congress* first grants him a cause of action to enforce individuals' federal constitutional or statutory rights: In the mid-twentieth century, the Attorney General repeatedly sought "broad power to seek injunctions against violations of citizens' constitutional rights," and Congress repeatedly refused to give him such power. *United States v. City of Philadelphia*, 644 F.2d 187, 195 (3d Cir. 1980). And for good reason: Allowing the Attorney General to seek invalidation of any legal rule he believes violates individuals' constitutional rights would amount to "government by injunction," a practice "anathematic to the American judicial tradition." *Id.* at 203.

2. Here, the Attorney General scarcely contests this general point but rather insists he must be able to sue to enjoin state conduct in what he claims are the "'exceptional' circumstances" presented here. Application at 28 (quoting App. 111a). The district court adopted this position, accepting the "three limiting principles" the Attorney General argues make this case exceptional. App. 49a. Yet these "limiting principles" are neither principled nor limiting. They lack grounding in any legal authority and would permit federal challenges to a wide variety of state laws.

At bottom, the position of the Attorney General and the district court is premised on the notion that the Constitution guarantees individuals the right "to vindicate their federal constitutional rights in federal court." Application at 28. The Constitution does not do so. As the Court has observed, the Constitution instead presumes "that state courts, as judicial institutions of co-extant sovereigns, are equally capable of safeguarding federal constitutional rights." *Hawaii Hous. Auth. v. Midkiff*, 463 U.S. 1323, 1325 (1983). The district court's order thus contravenes the Court's precedents—as well as the longstanding positions of both Congress and the Executive Branch—and threatens to undermine the principles of separation of powers and federalism that lie at the core of our Nation's constitutional structure. The Court should therefore reverse the district court's order and reject this unprecedented assertion of executive authority.

ARGUMENT

I. As Even the Attorney General Seems to Acknowledge, He Lacks a General Cause of Action in Equity to Challenge State Laws as Violative of Individual Constitutional Rights

Before suing a State, the federal Executive Branch, "like any other plaintiff . . . must first have a cause of action against the state." *United States v. California*, 655 F.2d 914, 918 (9th Cir. 1980). Because this suit fails to clear this threshold, it fails at the outset, and the district court therefore erred in granting the preliminary injunction.

Notably, unlike situations where the Attorney General has brought suit to enjoin a state law to enforce the federal government's *own* rights and powers—such as its "constitutional power to 'establish an uniform Rule of Naturalization,' and its inherent power as sovereign to control and conduct relations with foreign nations," *Arizona v. United States*, 567 U.S. 387, 394–95 (2012)— here the Attorney General seeks to enjoin every application of S.B. 8 on the ground that the law violates the purported *individual* right declared in *Casey*, *see Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992); Application 14–15. The Attorney General must therefore identify *something* authorizing him to seek this injunction to enforce private individuals' constitutional rights, and neither he nor the district court have suggested that any statute does so. The contention, rather, is that the Constitution itself—the Fourteenth Amendment or Supremacy Clause—provides the cause of action. *See id.* at 20 (contending "the law's violation of the Fourteenth Amendment and the Supremacy Clause injures the United States' sovereign interests"); App. 57a (arguing that there is an "equitable cause of action" because S.B. 8 attempts to "supersede the Supremacy Clause and the Fourteenth Amendment").

The Attorney General's argument on this score, however, runs headlong into the Court's precedents. *See Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 324–25 (2015) ("[T]he Supremacy Clause . . . certainly does not create a cause of action."); *Lampf, Pleva, Lipkind, Prupis & Petigrow v. Gilbertson*, 501 U.S. 350, 365 (1991) (Scalia, J., concurring in part and

concurring in judgment) ("Raising up causes of action where a statute has not created them may be a proper function for common-law courts, but not for federal tribunals."). The Court has long held that implied rights of action are disfavored: "In both statutory and constitutional cases, [the Court's] watchword is caution." *Hernandez v. Mesa*, 140 S. Ct. 735, 742 (2020); *see also, e.g., Ziglar v. Abbasi*, 137 S. Ct. 1843, 1856–58 (2017); *Alexander v. Sandoval*, 532 U.S. 275, 286–93 (2001).

Accordingly, "almost every court that has had the opportunity to pass on the question" has agreed "that the United States may not sue to enjoin violations of individuals' fourteenth amendment rights without specific statutory authority." *United States v. City of Philadelphia*, 644 F.2d 187, 201 (3d Cir. 1980); *see also United States v. Mattson*, 600 F.2d 1295, 1297 (9th Cir. 1979) ("[T]he United States may not bring suit to protect the constitutional rights of [individuals in state mental-health facilities] without express statutory approval . . . ."); *United States v. Solomon*, 563 F.2d 1121, 1129 (4th Cir. 1977) (similar).

The political branches have long shared this understanding as well. The mid-twentieth century saw the federal Executive Branch make "several attempts extending over a period of twenty years," *Solomon*, 563 F.2d at 1125 n.4, to convince Congress to enact legislation authorizing the Attorney General to "seek injunctions against violations of citizens' constitutional rights," *City of Philadelphia*, 644 F.2d at 195.

Officials, including multiple Attorneys General, seriously debated these legislative proposals and clearly believed they would *change* the Executive Branch's *lack* of authority on this score: "Those officials did not act out a meaningless charade, debating whether to create what they believed already existed, but in a serious and responsible manner decided for reasons of constitutional principle and sound public policy not to create new federal authority over state and local governments." *Id.* at 201; *see also id.* at 195 (quoting the Attorney General's observation that under current law conspiracies to violate constitutional rights "'can be redressed only by a civil suit by the individual injured thereby'" (citation omitted)).

Furthermore, while these particular proposals met with Congress's "express refusal[]," *id.* at 195, Congress has in fact occasionally provided the Attorney General narrow authority to sue States to seek injunctions against violations of certain constitutional or statutory rights, *see, e.g.,* 42 U.S.C. § 2000a-5 (Title II of the 1964 Civil Rights Act); 52 U.S.C. § 10306(b) (poll taxes); 52 U.S.C. § 10504 (Voting Rights Act). And if the Attorney General possessed an inherent equitable cause of action to sue States to enjoin violations of individual rights, such provisions would plainly be unnecessary.

This evidence thus "demonstrates that neither Attorneys General nor Congress . . . believed that either Congress or the Constitution had created this power sub silentio." *City of Philadelphia,* 644 F.2d at 201. Congress has repeatedly addressed the issue and has

determined that the Attorney General's authority to enforce individuals' Fourteenth Amendment constitutional rights should be limited to the criminal prosecution of certain constitutional violations. *See* 18 U.S.C. §§ 241, 242; *City of Philadelphia*, 644 F.2d at 190–93 (discussing these two statutory provisions). Otherwise, Congress has left the enforcement of constitutional rights to the individuals who bear them. *See* 42 U.S.C. § 1983. In short, "Congress could not more clearly and emphatically have withheld [the] authority" the Attorney General claims here. *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 602 (1952) (Frankfurter, J., concurring).

The district court responded to this overwhelming evidence with a non sequitur: This "history has little bearing on the action here," it argued, because these "legislative debates . . . occurred between 1957 and 1964, placing them a decade before the Supreme Court first recognized the right to abortion in *Roe v. Wade*, 410 U.S. 113 (1973)." App. 53a. Yet not even the district court suggested that among constitutional rights abortion is somehow uniquely amenable to federal Executive Branch enforcement. And neither *Roe* nor any other abortion-rights precedent says anything about the Attorney General's authority to seek injunctions against States to enforce abortion rights. Regardless of the constitutional right at issue, "the longstanding and uniform agreement of all concerned" is that "the fourteenth amendment does not implicitly authorize the United States to sue to enjoin violations of its substantive prohibitions." *City of Philadelphia*, 644 F.2d at 201.

Other than a 1963 opinion whose constitutional reasoning was later disavowed by two-thirds of the panel, *see United States v. City of Jackson, Miss.*, 320 F.2d 870 (5th Cir. 1963), the district court cited just one other authority on this point: *In re Debs*, 158 U.S. 564 (1895). *See* App. 47a. Yet this one-and-a-quarter-century-old decision, which permitted the federal government to enforce an anti-strike injunction quelling violent railroad labor unrest, vindicated no private rights and invalidated no state laws; rather, the suit was premised on the federal government's property interests in the mail, its constitutional authority over interstate commerce, and the "public right" in unobstructed interstate rights of way. 158 U.S. at 592. As the Fourth Circuit has observed, in *Debs* "Congress had exercised the constitutional power" at stake, which in turn "was impugned by the action sought to be redressed." *Solomon*, 563 F.2d at 1127. No such congressional exercise of authority is present here. Furthermore, "the harm was a public nuisance, and there was a statute [the Sherman Act] authorizing suit on which the decision could have been grounded." *Id.* This case presents no public nuisance, no statute on which the action could be grounded, and no "interferences, actual or threatened, with property or rights of a pecuniary nature." *Debs*, 158 U.S. at 593.

Expanding *Debs* to permit federal equitable enforcement of individual constitutional rights absent a statutory cause of action would undermine the Court's "traditionally cautious approach to equitable powers, which leaves any substantial expansion of

past practice to Congress." *Grupo Mexicano de Desarrollo S.A. v. All. Bond Fund, Inc.*, 527 U.S. 308, 329 (1999). And if the Court "were to read *Debs* to authorize this suit," it would "authorize the executive to do what Congress has repeatedly declined to authorize him to do." *Solomon*, 563 F.2d at 1129. The Court should refuse to do so.

II. The "Exceptional Circumstances" the Attorney General Cites as Limiting Principles Lack Legal Significance and Are Far from Exceptional

As it happens, neither the Attorney General nor the district court "go so far as to endorse the broadest reading of *Debs*." App. 48a. Indeed, the Attorney General has expressly disclaimed the notion that he may sue States "whenever a State enacts an unconstitutional law." Application at 22. Instead, the Attorney General suggested, ECF 8 at 26, and the district court accepted, three conditions that would limit the proposed equitable cause of action to the "circumstances present here"— "(1) a state law violates the constitution, (2) that state action has a widespread effect, and (3) the state law is designed to preclude review by the very people whose rights are violated," App. 49a.

These purported limitations, however, have no legal basis and impose no real constraints. As to the first two, the district court did not even attempt to explain their legal relevance or practical significance—and no such explanation is conceivable. The first pro-

posed condition, that "a state law violates the constitution," cannot possibly justify recognizing a novel equitable cause of action, for it simply states a universal requirement for enjoining a law: If a state law does not conflict with federal law, obviously a federal court cannot enjoin the state law's enforcement. Similarly, the second purported condition, that the state law "has widespread effect," has neither legal relevance nor any capacity to narrow when the federal government may sue: By their very nature, *all* state legal rules have statewide effect.

The district court and the Attorney General thus rely heavily on the third condition, that the state law is "designed to preclude review." *See* App. 49a ("The final factor identified by the United States will likely carry the most weight . . . ."); Application at 28 (distinguishing "*City of Philadelphia*, *Mattson*, and *Solomon*" solely on the ground those cases "involved no effort to frustrate other mechanisms for judicial review"). But this condition, like the others, also lacks legal justification and practical significance. The district court offered the theory that a lack of federal-court review satisfies the traditional equitable requirement that there be "no adequate remedy at law," App. 44a, but equity *always* requires the absence of adequate legal relief, *see, e.g., Monsanto Co. v. Geertson Seed Farms*, 561 U.S. 139, 156 (2010). This condition thus does nothing to identify an "exceptional circumstance" where the federal government has an otherwise-unavailable equitable cause of action.

Meanwhile, the rationale the Attorney General offers—that *Ex parte Young* guarantees challengers a right "to vindicate their federal constitutional rights in federal court," Application at 28—fails as well, for the problem in *Ex parte Young* was that the law had "preclude[d] a resort to the courts (*either state or Federal*) for the purpose of testing its validity," 209 U.S. 123, 146 (1908) (emphasis added). Here, state courts *are* available to test the constitutionality of S.B. 8. *See Whole Woman's Health v. Jackson*, 13 F.4th 434, 447 & n.20 (5th Cir. 2021) (noting "that potential S.B. 8 defendants will be able to raise defenses before state courts that are bound to enforce the Constitution" and citing pending state-court challenges). While the district court doubted that state courts could vindicate federal rights because S.B. 8 purports to limit available defenses, *see* App. 44a, Texas law clearly permits litigants to challenge the constitutionality of statutory limits on defenses in state court, *see State v. Scott*, 460 S.W.2d 103, 107 (Tex. 1970) (holding that the Texas Rules of Civil Procedure "authorize pleading of every conceivable defense in an answer, including unconstitutionality of a statute on which suit may be based"). And of course, whatever decision a state court might reach, its resolution of federal constitutional questions is reviewable by this Court via a writ of certiorari. 28 U.S.C. § 1257(a).

In any case, the Attorney General's theory necessarily presumes "that "state courts [a]re not competent to adjudicate federal constitutional claims," a notion this Court has "repeatedly and emphatically re-

jected." *Moore v. Sims*, 442 U.S. 415, 430 (1979). Indeed, his theory contravenes the very foundations of the Madisonian Compromise, whereby the Constitution created the Supreme Court but not lower federal courts—thus presuming that *state* courts are in fact capable of resolving federal constitutional claims in the first instance. *Printz v. United States*, 521 U.S. 898, 907 (1997) ("In accord with the so-called Madisonian Compromise, Article III, § 1, established only a Supreme Court, and made the creation of lower federal courts optional with the Congress—even though it was obvious that the Supreme Court alone could not hear all federal cases throughout the United States.").

After all, many legal rules can be adjudicated only in state-court proceedings, with the resolution of federal claims reviewable by this Court. *See, e.g., New York Times v. Sullivan*, 376 U.S. 254, 264 (1964) (reviewing a defamation suit that wound its way through state courts and holding that applicable state-law rule was "constitutionally deficient"); *Espinoza v. Mont. Dep't of Revenue*, 140 S. Ct. 2246, 2252–53, 2661 (2020) (reversing on Free Exercise Clause grounds a Montana Supreme Court decision construing state scholarship program to exclude religious schools under state constitution's "no-aid" clause). Other examples include due-process challenges to state rules governing punitive damages and personal jurisdiction, *see, e.g.*, *State Farm Mut. Auto Ins. Co. v. Campbell*, 538 U.S. 408 (2003) (punitive damages); *World-Wide Volkswagen Corp. v. Woodson*, 444 U.S. 286 (1980) (personal jurisdiction); state criminal cases, where defendants may challenge any number

of state rules of criminal law or procedure by invoking the federal Constitution, *see, e.g., Ramos v. Louisiana*, 140 S. Ct. 1390 (2020) (unanimous juries); *Medina v. California*, 505 U.S. 437 (1992) (burden shifting); and other due-process challenges to state procedures, *see, e.g.*, *Stanley v. Illinois*, 405 U.S. 645 (1972) (due-process challenge to state rule that failed to provide an unwed father a parental-fitness hearing before taking his children). There can therefore be no suggestion that the practical unavailability of federal-court pre-enforcement challenges to state legal rules presents any constitutional problem.

Finally, beyond these three express limitations, the district court suggested this suit is permissible because, as in *Debs*, "the offending law implicates interstate commerce." App. 48a. Yet again, however, this argument offers neither a legal justification nor a significant limitation on the Attorney General's authority to challenge state laws. *Debs* provides no legal rationale, for it involved no "offending law" at all, and the private activity that had been enjoined there far more than "implicate[d] interstate commerce," *id.*—it constituted "forcible interference" with interstate commerce and thereby violated the federal government's constitutional "power over interstate commerce and the transportation of the mails," *In re Debs*, 158 U.S. 564, 581 (1895). Here, the claim is not that S.B. 8 violates the Commerce Clause, but that it violates the putative right of individual women to pre-viability abortions. If the Attorney General can seek injunctions to enforce such individual rights any time a state law merely "implicates" interstate commerce,

App. 48a, his authority on this score would be expansive indeed. *See, e.g., Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 536–37 (2012); *Taylor v. United States*, 136 S. Ct. 2074, 2086 (2016) (Thomas, J., dissenting).

***

This case does not permit, much less require, the Court to address the constitutional merits of S.B. 8, but instead presents a legal question of considerable significance for federalism and the separation of powers—whether the Attorney General has inherent authority to seek injunctions against state laws as violative of individual constitutional rights even absent congressional authorization. *See United States v. Solomon*, 563 F.2d 1121, 1129 (4th Cir. 1977) ("[W]hen the executive acts in an area in which he has neither explicit nor implicit statutory authority, 'what is at stake is the equilibrium established by our constitutional system.'" (quoting *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 638 (1952)). The Attorney General has effectively conceded he has no such authority—at least as a general matter. And just as in *City of Philadelphia*, where the Attorney General (unsuccessfully) assured the court that "the asserted right of action w[ould] be limited to 'exceptional' cases involving 'widespread and continuing' violations, for which the remedies expressly provided [were] not 'adequate,'" the limiting principles proposed here "lack real content." *United States v. City of Philadelphia*, 644 F.2d 187, 201 (3d Cir. 1980).

In sum, every relevant precedential and historical authority points to the same conclusion: The Attorney General has no authority to act as a roving reviser of state law, challenging as unconstitutional any rule with which he disagrees. Congress has repeatedly refused to grant the Attorney General such authority. The Court should refuse to do so as well.

CONCLUSION

The Court should reverse the district court's preliminary injunction.

Respectfully submitted,

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Attorney General
Commonwealth of
Kentucky

JEFF LANDRY
Attorney General
State of Louisiana

LYNN FITCH
Attorney General
State of Mississippi

ERIC SCHMITT
Attorney General
State of Missouri

AUSTIN KNUDSEN
Attorney General
State of Montana

DOUG PETERSON
Attorney General
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State of Oklahoma

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State of Utah

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Attorney General
State of South Carolina

PATRICK MORRISEY
Attorney General
State of West Virginia

JASON R. RAVNSBORG
Attorney General
State of South Dakota

Counsel for Amici *States*

Mr. OWENS. I would like to share my perspective on the devastating impact abortion has had on my community. In June of this year, I wrote an op-ed on why Planned Parenthood is the greatest threat to Black lives in America. I would like to request unanimous consent to enter that full piece into the record.

Ms. JACKSON LEE. Without objection, so ordered.

[The information follows:]

MR. OWENS FOR THE RECORD

A

OPINION: Planned Parenthood Is The Greatest Threat To Black Lives In America

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The headline in a recent weekend edition of *The New York Times* was stark, "I'm the Head of Planned Parenthood: We're Done Making Excuses for Our Founder." The author of the piece, Alexis McGill Johnson, went on to proclaim that her organization, the prime progenitor of abortion in the United States and perhaps worldwide, would have to "reckon" with their founder, Margaret Sanger, and her association with "white supremacist groups and eugenics."

The acknowledgement of Sanger's notorious views on Planned Parenthood's use of birth control to eliminate those she regarded as nothing but "human weeds" — by such methods as forced sterilization, birth permits and segregated camps for the unfit — is important. But Johnson's confession is short on specifics, and to say it is overdue is like acknowledging the *Hindenburg* had a fire on board.

Margaret Sanger's Planned Parenthood has spent more than a century building a citadel of prejudice with profound, even irreversible, effects on African Americans and the poor.

It is too bad that we know no more about Sanger's 1926 address to a women's auxiliary of the Ku Klux Klan in New Jersey than her self-report, in her autobiography, that the audience reaction was enthusiastic and led to "a dozen invitations to speak to similar groups." In short, she resonated. Her views not only had long-term influence on the location of Planned Parenthood clinics, but they also helped drive passage of the infamous federal anti-immigration legislation of 1924 and praise for the Supreme Court's decision upholding the constitutionality of forced sterilization laws in *Buck v. Bell* in 1927.

Nearly a century later these impacts are still being felt. America has become so used to the disparate impact of abortion on U.S. minorities that some actually advocate for public funding of abortion because it will result in even more abortions. Today in the United States, the abortion rate of African American women is over three times that of white women. Planned Parenthood, which has only sporadically reported the abortions it performs by race, owns roughly 40 percent of this traffic. From 2000 to 2010 African Americans as a percentage of the total U.S. population dropped by one seventh. What an incalculable loss to our national and community well-being this is.

How might Planned Parenthood reckon with its sordid past? Recognition is a first step, but clearly much more is necessary. However unlikely, the group might begin with a recognition that every human life is of equal worth, regardless of that life's parentage, potential scores on competitive tests, country of origin, religion, or skin color. Planned Parenthood might begin to scorn those who say prenatal disability, or sex, or race are grounds for "termination" of human life by dismemberment that tears bodies limb from limb and shreds the dreams of the vulnerable.

Planned Parenthood might take another look at the effort by the Mississippi legislature to protect babies at and after 15 weeks of pregnancy. An analysis of Mississippi's 2019 annual abortion report by the Charlotte Lozier Institute shows that an astonishing 2,366 – that is 74% – of the state's 3,194 abortions were inflicted on black women. These numbers represent a failure of health care – its very antithesis.

Planned Parenthood might even consider some of the bright spots in its history, those rare moments when, through a program like the Mississippi Health Project, Dr. Dorothy Ferebee, a Planned Parenthood board member, teamed with Ida Jackson and the international AKA Sorority to bring mobile clinics to Mississippi's rural poor women. This effort, which brought as many as 46 black female physicians to the state during the summer months, remains one of the most impressive examples of voluntarism in the history of the Jim Crow South.

Our call is clear. It is indeed time to stop making excuses — and to start making amends. Our nation needs a clarion summons for both racial reconciliation and a renewed reverence for life. The real freedom to choose is the choice for love and respect for the youngest and weakest in our midst.

Marjorie Dannenfelser is president of Susan B. Anthony List.

Burgess Owens is the U.S. Representative of Utah's fourth congressional district.

The views expressed in this opinion piece are the author's own and do not necessarily represent those of The Daily Wire.

Mr. OWENS. Here's a few highlights. A highlight in a recent weekend edition of *The New York Times* was stark, on the head of Planned Parenthood, "We're done making excuses for our founder."

The author of this article, Alexis Miguel Johnson, said that her organization, the largest provider of abortion in the United States and perhaps the world, would have to reckon with Margaret Sanger and her association with the White supremacist groups and eugenics.

It's important to acknowledge Sanger's views on Planned Parenthood's use of birth control to eliminate those she considered nothing but human weeds.

What does targeting race as human weeds look like? Black women represent six percent of America's population yet make up 40 percent of women who end up on the operation table of a wealthy abortionist.

Twenty million Black babies have been exterminated over the last 40 years, represents 40 percent of my race as viewed by the left as nothing but human weeds.

In a civilized country, the death of 40 million Black innocent babies in combination with over 60 million babies of all race and colors would be considered genocide.

The left considers this medical care, and the death of all these innocents is love and blessings. The left preaches us about equity. Where's the equity when the lowest percentage of Americans are killed at a higher rate than the majority race?

Today in the U.S., the abortion rate of African American women is over three times that of White women. From 2000–2010, African Americans as a percentage of the total U.S. population dropped one-seventh percent. We have a party that actually believes that stopping the killing of Black babies at a rate three times more than White babies is not fair to Black mothers.

No, my friends, Black babies are not human weeds, and our communities should celebrate—should not celebrate throwing them away. Black mothers would love their children as much as White mothers if they were only taught at a young age that it's not cool to abort them, if they were taught that it is not liberation and should not go—liberating them from going through the hassle and innocence of being a mother.

Twenty million children destroyed in 40 years, how many of them if allowed to live would have solved our climate crisis? Been the next Martin Luther King to unite all races? Another Ben Carson, leading our nation against the fight of cancer and heart disease? What a crushing loss to our national community and well-being.

No, losing our precious babies for billions in profit to an abortion industry is not love and blessings to the mother and lives, to the lives of millions that have been destroyed, mothers and babies.

Justice Clarence Thomas may have put it best when he wrote that, "technological advances have only heightened the eugenics potential for abortion, as abortion now can be used to eliminate children with unwanted characteristics."

This law and other laws like it promote the State's compelling interest of preventing abortion from becoming a tool of modern-day eugenics.

I'm the father of six children and 15 grandchildren. My life has been one, like everyone in here, has gone up and down, from being a Super Bowl champion to losing everything, going through bankruptcy, living in a one-bedroom basement apartment in Brooklyn with four kids.

We chose to have another two because we believe in the blessings of the eternal life of families. I'm going to give a message to those who are listening. Do not listen to the dark message of hopelessness. The tough times you might go through are temporary.

The life that you give to your children, which you build as a family, is eternal. There is nothing like the memories I now share and believe that it's not playing on a football field that makes a difference today.

It's watching my six kids, my 15 grandkids, how tight and how close we are, how much enjoy our company and the pride I have in what they've done to raise their kids. That's the legacy of moms and dads.

That's the legacy that many moms will never ever have because they've been taught that killing a baby is cool. Many dads will not have because they've been taught it's better to go to an abortion center than man up and take care of their child.

Vote for life. Live your life. I give back my time.

Ms. MCBATH. Thank you, Madam Chair, and thank you to you for being here today for such a lengthy bit of time to just really discuss this serious attack on our constitutional rights. I can't tell you how much this means to me.

Generations of women have fought for their place in society. They fought for the right to vote. They fought for a seat in the university classroom, a seat in the boardroom and a seat in our own government, and they fought for the freedom to make our own decisions about our bodies, health, and families.

Generations of women secured these gains so that we could build on their efforts toward a just and equitable society. We cannot allow the work to be undone. We've seen attempts to legislate away women's personal decisions time and time again.

These efforts always caused the greatest harm to women of color and those without resources, as we've discussed over and over again today, those who face the greatest obstacles to traveling long distances just to get the care that they need.

This attack also poses a grave new risk that any of our constitutional rights could become the focus of a strange system of vigilante justice, a system in which a neighbor is pitted against neighbor, eroding the sacred trust that binds our communities, and I am deeply troubled by what this law could mean for the constitutional right to abortion and all our constitutional rights if this vigilante scheme is allowed to continue and be replicated.

I'm so pleased today that we are able to shed light on the experiences of people in Texas that are already—this is already happening to them right now, and that we will continue to see this spread throughout the country if our courts are not going to uphold the Constitution.

Before we get started today, I just want to know, Professor Bridges, is there anything that you would like to respond to?

Dr. BRIDGES. Oh, my God, thank you so much for the opportunity to respond. I would love to respond to some of the comments that were just made by Representative Owens.

He speaks about the higher rates of abortion among Black people. He doesn't mention the reasons for that. The reasons for the higher rates of abortion are not because Black people have been taught that abortion is cool.

The reason for the higher rates of abortion is due to poverty, is due to the lack of access to contraception. It's due to the fact that people are not being educated about sex and pregnancy in public schools.

It's due to the inaccessibility of healthcare. So those are the reasons for the higher rates of abortion among Black people. The suggestion that Black people are terminating pregnancies because we think it's cool suggests that he thinks that Black women are stupid.

I assure you, Black people are not stupid. They're using abortion care to exact some modicum of control over their lives, especially when they're mired in structural conditions that make it impossible for them to control their lives otherwise.

He didn't mention at all what happens when we restrict abortion. We force birth. People are ignoring that throughout this entire hearing. We're forcing birth.

Particularly, we need to pay attention to the fact that we're forcing Black people to give birth in a country in which we have terrible rates of maternal mortality compared to our peers and we have racial disparities in maternal mortality, meaning that three to four times as many Black people should expect to die during pregnancy, childbirth, or shortly thereafter.

So, we're forcing Black people to engage in a task that is dangerous to their lives.

Finally, we live in a country in which poverty is defined as neglect and that Black people can expect to have their children taken away from them by the child welfare system, by the family regulation system.

This is a cruel set of circumstances that we're creating where we force birth, we force people to engage in a task that it's dangerous to them—Black people to engage in a task that is dangerous to them, and then we have them create families that we so easily dissolve through the family regulation system.

So, I think it's important to understand all that context and not to attribute the rates of abortion among Black people to we think it's cool.

Ms. MCBATH. I want to thank you very much for expanding upon that and telling us the truth of the nature of what's really happening in the country.

Dr. Moayedi, your testimony notes that SB 8 will have consequences for people with highly desired pregnancies who have pregnancy complications. Can you expand on those complications that might lead a doctor to discuss the option of abortion even when a pregnancy is wanted?

Dr. MOAYEDI. Yes. So, even at maybe 15–16 weeks, a bag of water can break the amniotic fluid. This is a condition where the treatment is—

Ms. JACKSON LEE. The gentlelady's time has expired.

Mr. McClintock is recognized for five minutes.

Mr. MCCLINTOCK. Thank you, Madam Chair.

I've spent 35 years either in the California State legislature or here in the Congress, and this is a debate that is very familiar. It's been going on without resolution on either side all those years.

I've always been pro-life. I've always voted that way. I think with respect to the Texas bill, I'd prefer a standard be the heartbeat and brain activity. At least the Texas standard gives us a rational and science-based standard to begin discussing.

That said, my personal opinion is the Texas law is bad law. I think it's very dangerous to enforce criminal law and civil courts to replace public prosecutors with freelance litigators.

Criminal courts are there for a reason. They require a higher standard of proof than the civil courts. They require unanimous jury verdicts. That's to assure that if we are going to use government power to injure someone, either to deprive them of their freedom or their property, it has to be done with these standards and safeguards.

So, I'm not entirely unsympathetic to the opponents of the bill. The enforcement mechanisms of this law are, to my eye, too clever by half. That is the matter that the Supreme Court is considering right now, and rightly so.

We may like their decision. We may not like their decision. If we don't like it, we are the Congress. It's our job to produce legislation to address our objections.

It is not clear to me what we're doing here today except trying to bring inappropriate pressure to the court or to politicize its deliberations.

I, frankly, don't have any questions of the Witnesses before us because they appear to be incapable of responding in any other fashion other than repeating predetermined sound bites.

If Mr. Owens would like to have another crack at it, I'll be happy to yield the balance of my time to him.

Mr. OWENS. Thank you so much. Just wanted to make a couple comments.

This is the first time in my lifetime heard that Black people having a family is dangerous. I have a feeling all races deal with the same issues when having babies and overcoming obstacles. It's called life. I've never heard that it's dangerous to have a baby.

I think part of this is the low expectations that so many people have of my race. It bothers me tremendously.

Ms. JACKSON LEE. Would the gentleman yield?

Mr. OWENS. No. I'm sorry. Let me just finish up. I'm sorry.

I want to continue to repeat because I know people have not heard this, I lived in a time when my race was literally one of the best, most progressive and productive races of our country.

We led our country in the growth of the middle class, men matriculating from college, men committed to marriage. A Black woman could expect to be married before—in higher rates than White women until 1970. That's the environment. Believe me, in those days abortion was not prevalent in my race because it was expected men to take care of their families.

That's right, it was not prevalent in my race in the 1960s. I was there. I know that. Okay. Anyway, so I'm sorry, I didn't mean to have this exchange. It's interesting when we have facts, we have experience, and people who have no clue are experts.

So, I just want to say this, my friends. We have options. When it's being hopeful that we overcome obstacles, having a belief that our kids are precious, that our legacy be put in place and in a way that our name will be a good name, we can be proud of our kids.

I'll tell you something I find interesting is how very wealthy people do not even consider abortion. Very wealthy people love their kids, and they will have their kids as they tell the rest of the society—the poor—how they should stay hopeless and kill their kids.

Let me just say this. If we're going to ever get our family back, it comes down to loving the family unit. It comes down to us deciding that it's worth the price to do whatever we can to save, to work, to sacrifice, like every other race has done before now, and realize that those kids growing up will love themselves because they learned—they see what it is to be loved in their household.

We are having problems in our family right now, the Black family, because kids are growing up realizing they have no wealth—they have no worth. They're told early how easy it is and how cool it is to have abortions. If they don't want to really deal with it, Planned Parenthood, they'll take that issue off your shoulders in a heartbeat, of course, full price.

Let's back to understanding that our children are gifts from God, period, and if we are given the opportunity to work our very best to help them, support them to raise them, we'll get help from God to do just that, and our country will come back in a big, big way.

I yield back.

Ms. JACKSON LEE. The gentleman yields back.

I yield myself just a moment to indicate that the highest maternal mortality is among women of color, particularly African Americans.

Mr. MCCLINTOCK. A point of order. A point of order, Madam Chair. On whose time is the Chair speaking?

Ms. JACKSON LEE. Mine, to correct the record. I'd like to yield to the gentleman, Mr. Stanton, for five minutes.

Mr. MCCLINTOCK. You don't have time, Madam Chair.

Mr. STANTON. Thank you, Madam Chair.

Ms. JACKSON LEE. Thank you.

Mr. STANTON. I want to thank our Witnesses for joining us here today and your patience with a long day up here on Capitol Hill. Your testimony today is crucial for the work of this Committee and for our Congress.

Every person deserves access to reproductive healthcare that is safe and affordable. It is a fundamental constitutional right recognized by the United States Supreme Court now for nearly 50 years.

Unfortunately, since *Roe* v. *Wade* was decided, too many State governments across our nation have set their sights on eliminating this constitutional right. In States like mine, in Arizona, legislatures and governors have chipped away at it, inserting their own personal views into conversations between a woman and her doctor and setting up roadblock after roadblock.

In Arizona, to obtain an abortion the State law requires people to visit their doctor twice 24 hours apart to be read a government-mandated script and obtain an ultrasound, all obstacles that do not prioritize health or safety.

What's more, Arizona is one of nine States that still has pre-*Roe* abortion ban on the books. Now, emboldened by justices appointed to the Supreme Court by the previous Administration, some States have gone even further, attempting to effectively ban abortion completely.

That's what happened in Texas where Senate Bill 8 has sought to see these fundamental rights stripped away and in Mississippi where the legislature has passed a facially unconstitutional law with the expressed intent of challenging *Roe*.

These are laws that affect every State because I have grave concerns that the protections of *Roe* and its progeny may be erased by the Supreme Court. It's one of the reasons that I cosponsored and voted for the Women's Health Protection Act, which would enshrine a woman's right to choose in Federal statute.

What we know is that these anti-choice laws disproportionately affect low-income communities and communities of color. If *Roe* were overturned, Arizona would become one of several States where abortion was outlawed and my constituents would no longer have access to the reproductive healthcare that is their right.

I have a question for Dr. Moayedi.

Doctor, how do excessive restrictions force providers to go against their expert medical judgment and prevent them from providing the very best care possible to their patients?

Dr. MOAYEDI. Thank you so much for that question. I have so many examples of how these restrictions impact evidence-based care.

So, in Texas we have a law that requires that I provide medication abortion per the FDA label. There is no other area of medicine where a State law requires following the FDA label. This becomes problematic because the second medication used in medication abortion, misoprostol, can be taken in different ways.

The FDA label says that it has to be placed in the sides of the cheeks, but that medication can actually be swallowed, it can be placed under the tongue, or can be placed in the vagina and also works in the process.

Because of that law, when I have patients with unique medical conditions that might prevent them from taking that medication orally, ordinarily, I would recommend that they take that medication vaginally, and when I practiced in Hawaii that's what I would do. I would tell them to take the medication vaginally.

So, for example, if someone has Crohn's disease or IBS, they might not want to take it orally. They would take it vaginally. In Texas, I can't tell them to do the best thing for their health in that process because the State restricts evidence-based care. So, that's one example right there.

The State has just passed or the Fifth Circuit has upheld a ban on second trimester procedures, and so now we—once, hopefully, SB 8 is overturned, the State actually tells me how to operate.

So, there's nowhere else in my gynecologic practice where the State would tell me that you need to do the hysterectomy like this,

that you should put the clamp here and you should do the incision there.

That's not how we practice medicine at all. Now, I'm at risk for a criminal penalty for doing a procedure in the wrong way, the way that the State doesn't want me to do. This doesn't make any sense.

Mr. STANTON. Thank you. I really appreciate that answer. I have 30 seconds left.

Professor Bridges, I do want to give you one additional opportunity to respond to anything one of my colleagues may have said earlier that you would like to respond to.

Dr. BRIDGES. Yes. Thank you again for the opportunity.

I would just encourage Representative Owens to Google racial disparities in maternal mortality and morbidity. I've actually written an article about that. It's in the NYU Law Review. It gives you a lot of information about how it's dangerous to undergo childbirth.

I would just like to just note for the record that there were a lot of fact-free claims that Representative Owens made—wealthier people don't have abortions because wealthier people love their children. So, it's just the fact-free level of these claims were remarkable.

Mr. STANTON. Thank you, Professor. I yield back.

Ms. JACKSON LEE. The gentlelady from Pennsylvania is recognized for—

Ms. DEAN. Thank you, Madam Chair. I want to thank all our testifiers today. What patience you have shown for a very long day with a very difficult topic, but we really appreciate your personal experience, your expertise, and the value you bring to this conversation. So, thank you.

Ms. Piñeiro, I would like to particularly thank you for your personal story and for the advocacy that you bring and the courage that you show.

In reflecting on SB 8—and I told you this—I am reminded of a story of which is a story of my mother-in-law, Joan Canaan. She was the youngest of six children growing up in 1930 Scranton. Her mother became pregnant with a seventh child, and the doctors discovered that the child would be stillborn. They also knew that the mother would likely die in childbirth.

It was the 1930s. It was Scranton. It was a Catholic community. So, her family did not have a choice; the choice was with the government and with the church. Maybe the outcome would have been the same. Perhaps she would have chosen to go forward with that pregnancy. We don't know.

We will never know because she and her family had no choice. The baby was stillborn, and Joan's mother died in labor, forfeiting six young children. May we never go back to that.

This was the 1930s, some 90 years ago, and yet we are still discussing the merits or the right of a woman to choose. While we should all be alarmed at Texas' SB 8, the bill follows a long list of restrictions in Texas.

In fact, before this de facto ban, Texas had enacted 26 abortion restrictions to a woman's right to choose. These restrictions, or rules, on abortions include, but not limited to, State-mandated counseling to discourage women from having an abortion, a 24-hour waiting period, banning telehealth, requiring women to physically

visit their healthcare provider. Due to waiting periods and scheduling, we know the delays that causes; prevention of health insurance, and also, as the doctor told us, the offering of bad information to patients.

We can no longer say *Roe* v. *Wade* is the law of the land. So, Dr. Moayedi, could you elaborate on the impact some of these barriers have had on women in your practice? I would like to pick up on a question that my friend and colleague asked you. Can you expand on some of the complications, perhaps like the one I told you about my mother-in-law's mom, some of the complications that might lead a doctor to discuss the option of abortion even when a pregnancy is wanted?

Dr. MOAYEDI. Thank you so much for allowing me to continue. So, yes, at any point in pregnancy, for example, at 15 weeks, someone's bag of water can break. When that happens, there is no intervention that can help continue that pregnancy. There is no intervention that can assure life for that pregnancy, and so the recommendation at that point is delivery or a procedure, an abortion, to prevent death in that person.

This law, SB 8, prevents us from being able to do that, and we have to actually wait until the person is critically ill before we can intervene. So, that situation comes up quite a bit, where someone has pregnancy complication and a very highly described pregnancy, but the bag of water breaks, or they start hemorrhaging or bleeding very heavily, and we need to intervene.

There are also conditions that the fetus, the pregnancy itself, can develop that actually mirror a condition in the pregnant person. So, if a fetus develops severe what is called Hydrops, or takes on fluid in its body, there is a condition called mirror syndrome, and that can happen in a pregnant person, too, and cause death in them as well.

So, these are just a few examples, but there are literally hundreds and thousands of things that can go wrong during pregnancy. So, every pregnant person needs the option, the availability, to swift, expert abortion care to save their lives when they need it.

Ms. DEAN. Did any patient ever come to you saying, "I would like an abortion because it is cool?"

Dr. MOAYEDI. Never.

Ms. DEAN. I wouldn't think so. It is quite serious.

Dr. MOAYEDI. I find it incredibly insulting to hear that about women, but particularly about Black women. I trust Black women to make the best decisions for their families, and that includes abortion care.

Ms. DEAN. In the remaining—I have no time left. In any event, I would love to have had more conversation with you, Professor. I apologize. I will submit my question to you privately.

I yield back.

Ms. JACKSON LEE. Expired, and the gentlelady yields back.

I recognize the gentlelady from Texas, Ms. Escobar, for five minutes.

Ms. ESCOBAR. Thank you, Madam Chair. I first want to thank our panelists for sticking it out, being with us for a very, very long day here in our nation's capital. I also want to apologize for the in-

credibly shocking and disrespectful comments that have come from some of my Republican colleagues.

As a native and lifelong Texan, it has been heartbreaking to see my State lead the way in eroding decades of gains in voting rights, civil rights, human rights, and women's rights. We have talked at great length, and rightfully so, about the dangerous impact Texas SB 8's law has on women and on Texans. It also has a dangerous impact on providers.

Dr. Moayedi, throughout today's hearing, my colleagues across the aisle have cut you off and asked you questions in very bad faith. One of my colleagues just went so far as to dismiss your concerns about how the language that he uses endangers you and the rest of the Witnesses on this panel.

I would like for you to please explain to the public, and explain to our Committee, the danger that this rhetoric puts you and other abortion service providers and advocates in.

Dr. MOAYEDI. Thank you so much for that question, Representative, and thank you for your service to our State. Anytime there is a hearing like this, Federally or locally in our legislature, we see an increase in protesting and harassment outside of our clinics. I see personally an increase in letters, threats, harassment online, and by mail.

When the Representatives engage in this sort of conduct where they equate me or my colleagues here as murderers, right now, I have been receiving messages on Instagram and on Twitter saying that I am evil person, that I deserve to die. Right?

I am a mom, too. I am a person, too. I deeply care for my community. I am not in DC today, because last night I was delivering babies here in my community. So, I find it deeply troubling as a mom, as an OB/GYN, and a servant to my community that people would speak about me in this way and put me in danger. Put me in danger.

These people have yelled in my face before, but also yelled in my child's face before. That is not something who cares about children at all.

Ms. ESCOBAR. I think representing a community—El Paso, Texas—that understands the power of words and the consequences of words, I think what we have seen here on this Committee coming from the dais is the use of words that are intended to fuel anger and possibly very dangerous consequences. So, I thank you for sharing that with me.

I have a follow-up question for you. Throughout the hearing, you have been interrupted. Things have been said that you have wanted to respond to but have not been able to respond to. Is there anything that you heard here today about pregnancy, abortion care, or the impacts of SB 8 that you would like to clarify for the record using the remainder of my time?

Dr. MOAYEDI. Yes, I would love to. I want to start by saying that abortion has always existed. As long as people have given birth, they have had abortions. Abortion is a necessary part of our reproductive lives. Without access to abortion care, maternal health, and mortality is extremely in danger.

I also want to clarify that abortion is not always a tragic decision, that many people are resolute in their decisions. It is okay to

have one abortion. It is okay to have more than one abortion. Abortion is not dangerous. It is incredibly safe. In a State like Texas, it is 10–13 times safer than childbirth.

Every single person in our State deserves the right to become pregnant. They deserve the right to not be pregnant. They deserve the right to parent their children in safe and healthy environments.

If the Representatives here truly care about children and families, I would love to work with them on policies that truly elevate our communities. Right now, we are talking about paid parental leave, and so many Representatives here don't want to support parents after they give birth. That is one of the best things you can do to prevent infant mortality. It is one of the best things you can do to prevent postpartum depression.

I don't understand at all why they don't care about us and why they don't care about our families.

Ms. ESCOBAR. Thank you so much. There is clearly a difference between being pro-life and being pro-birth. Thank you for your testimony.

Madam Chair, I ask unanimous—or, Mr. Chair, I ask unanimous consent to submit into the record testimony from the Texas House Women's Health Caucus that was submitted to the Texas House.

[The information follows:]

MS. ESCOBAR FOR THE RECORD

TEXAS HOUSE
WOMEN'S HEALTH CAUCUS

Hearing before the House Committee on the Judiciary
Thursday, November 4, 2021

Written Testimony on behalf of the Texas Women's Health Caucus regarding
The Impact of Abortion Bans in Texas

Dear Chairman Nadler, Vice-Chair Dean, and distinguished members of the Committee:

Thank you for the opportunity to submit written testimony. Formed in 2005, the Texas Women's Health Caucus is an official caucus of the Texas House of Representatives and works to promote and defend women's health. The Caucus is currently composed of 52 Texas House members who work to ensure that all Texans have access to affordable, quality women's health services.

During the 87th Regular Session, the Texas Legislature endured many challenges. When we first arrived in Austin, the top priority was to address the COVID-19 pandemic. However, within weeks of convening, our state was faced with the failure of our power grid during a historic winter storm, resulting in hundreds of deaths. Amid these real and pressing issues, Republican leadership sought to divide the chamber in order to prioritize another unnecessary anti-abortion restriction. Senate Bill 8 (SB8), otherwise known as the "6-Week Ban," was passed in open defiance of the Constitution and upended decades of judicial and legislative precedent. In the weeks leading up to its final passage, the Caucus raised its concerns regarding the extreme nature of the bill. We tried to work with our Republican counterparts to fix these issues, but we could not convince the majority to sway from party lines. At this point, our only recourse is through federal action or a Supreme Court decision.

The Road to Senate Bill 8

Over the last decade, the members of our Caucus have been at the forefront of an unending legislative fight to protect access to women's health and reproductive services, including abortion care. Republican lawmakers who have held the majority of legislative seats for almost

two decades have enacted sweeping policy changes in every aspect of state government, particularly within women's healthcare.[1] In 2011, the state reduced funding for family planning services from $111 million dollars per year to $38 million dollars per year.[2] According to client-served data collected by the Department of State Health Services, in 2012, the fiscal year following this $73.6 million funding cut, clinics served 143,884 fewer Texans than they did in the previous fiscal year.[3] At the same time these funding cuts were going into effect, the Texas Health and Human Services Commission (HHSC) was in the process of renewing the state's 1115 Demonstration Waiver for its Women's Health Program (WHP). In the state's application, they included a provision which would ban any provider who chooses to "perform or promote elective abortions or that choose to be affiliates of entities that perform or promote elective abortions."[4] This change in policy, which came to be known as the "Affiliate Ban," would define women's health policy for years to come. The Ban allowed the state to block access to certain health care providers for reasons unrelated to the providers' ability to deliver quality women's health and family planning services.[5] The Centers for Medicaid and Medicare Services (CMS) ultimately denied Texas' request which prompted the state's exit from federal Family Planning programs and eventually led to the closure of more than 80 women's health and family planning clinics across the state.[6]

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[1] Ward, Mike. "Texas Tea Party: The Birth and Evolution of a Movement." *Houston Chronicle*, Houston Chronicle, 17 July 2017, https://www.houstonchronicle.com/news/houston-texas/houston/article/Texas-tea-party-the-birth-and-evolution-of-a-11292705.php.

[2] Potter, Joseph E, and Kari White. "The College of Liberal Arts the University of Texas at Austin." *UT College of Liberal Arts: TxPEP*, 27 Sept. 2021, https://liberalarts.utexas.edu/txpep/op-eds/washington-post.php.

[3] Potter, Joseph E. "The College of Liberal Arts the University of Texas at Austin." *UT College of Liberal Arts: TxPEP*, 27 Sept. 2021, https://liberalarts.utexas.edu/txpep/op-eds/statesman.php.

[4] *1115(a) Research and Demonstration Waiver, Texas Women's Health Program*. Texas Health and Human Services Commission, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Womens-Health-Waiver/tx-womens-health-waiver-research-demo-waiver.pdf.

[5] Pogue, Stacey. *Excluding Planned Parent Has Been Terrible For Texas Women*. Center for Public Policy Priorities, Aug. 2017, https://everytexan.org/images/HW_2017_08_PlannedParenthoodExclusion.pdf.

[6] Kari White, Kristine Hopkins, Abigail R. A. Aiken, Amanda Stevenson, Celia Hubert, Daniel Grossman, and Joseph E. Potter, 2015:
The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas
American Journal of Public Health 105, 851_858, https://doi.org/10.2105/AJPH.2014.302515

In 2013, in response to the federal government's decision, the state launched the Texas Women's Health Program (TWHP)- a fully state funded women's health program- with the affiliate ban in place and without any additional federal dollars.[7] At the height of the program, TWHP served 176,577 Texans.[8] It operated for two years before the Sunset Advisory Commission recommended the state dissolve the program and combine it with other existing family planning programs. Overall, in the first three years of the implementation of the Affiliate Ban and a fully state-funded program, the number of clients served by TWHP declined by 14.7 percent. In addition, between 2012 and 2016, 15 percent of adult women in Texas reported that they did not see a doctor during the previous 12 months due to cost.[9] The 84th Legislature approved the consolidation of women's health programs and directed HHSC to use $50 million to create a women's health program with the purpose of increasing access to women's health and family planning services.[10] In July 2016, HHSC launched the final version of its women's health program--Healthy Texas Women (HTW). Within months of the program's launch, it was clear HTW was not prepared to meet the needs of Texans. The program's provider capacity was substantially lower than it was under the WHP and served 35,577 fewer clients than TWHP did in 2015.[11] In fact, HTW only recently reached the same level of clients that the WHP served in 2011. Over the years, HTW has struggled to meet the healthcare needs of Texas, and Texas leadership has refused to do anything to enact legislation to change these circumstances. Each year, instead of allocating state dollars to increase women's health funding to ensure more Texans have access to the care they need, Republican leadership has allocated millions of dollars to the Alternatives to Abortion Program (A2A). The A2A program is made up of "crisis

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[7] *Final Report of the Texas Women's Health Program: Fiscal Year 2015 Savings and Performance*. Texas Health and Human Services, Mar. 2017, https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/former-tx-womens-health-program-fy2015-savings-performance.pdf.

[8] *Final Report of the Texas Women's Health Program: Fiscal Year 2015 Savings and Performance*. Texas Health and Human Services, Mar. 2017, https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/former-tx-womens-health-program-fy2015-savings-performance.pdf.

[9] *Overview of Women's Health Program*. Legislative Budget Board Staff Report, Apr. 2019, https://www.lbb.state.tx.us/Documents/Publications/Staff_Report/2019/5098_WomensHealthPrograms.pdf.

[10] General Appropriations Act, HB 1, 2015

[11] Evans, Marissa. "Texas Works to Market Health Program Without Planned Parenthood." *The Texas Tribune*, The Texas Tribune, 5 May 2017, https://www.texastribune.org/2017/05/05/healthy-texas-women-program-billboards-are-not-enough/.

pregnancy centers" who do not provide any healthcare services to pregnant people.[12] Instead, the program is best known for its misguided informational pamphlets and its ability to elude public accountability measures. Every year, women's health providers ask for an increase in funding and each time they are told there is simply not enough in the budget. The evidence is clear - the state's cut to women's health funding, in conjunction with the implementation of the Affiliate Ban, led to a reduction in women's health and family planning clinics which in turn led to a decline in the number of Texans receiving reproductive health services.

In order to fully understand the state of women's health services in Texas, one must recognize the onslaught of anti-abortion policy changes that were being enacted in tandem with the changes mentioned above. In 2011, the same year as the funding cuts, the state passed House Bill 15, otherwise known as the "Sonogram Law," which requires a physician to perform a sonogram not more than 72 hours and not less than 24 hours before the abortion and before any sedative or anesthesia is administered.[13] That law is a coercive attempt to dissuade a pregnant person from choosing to have an abortion by requiring a doctor to display the sonogram, make the fetal cardiac activity audible, and give a verbal explanation of the result of the sonogram to the pregnant person. Two years later in 2013, the Republican leadership passed an omnibus abortion bill, House Bill 2 (HB2), which imposed several new and unnecessary restrictions on abortion care. Among other requirements, HB2 required doctors to have admitting privileges at a hospital within 30 miles of the abortion facility; restricted access to medication abortion by forcing physicians to follow a state-mandated protocol rather than current, evidence-based protocols; and required abortion facilities to meet the standards of ambulatory surgical centers regardless of the procedures offered at the clinic. In addition, HB2 banned abortions after 20 weeks post-fertilization unless a patient is at risk of death or the fetus has a severe fetal abnormality. Upon passage of HB2, reproductive rights groups challenged various provisions of

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[12] Astudillo, Carla, and Shannon Najmabadi. "An Anti-Abortion Program Will Receive $100 Million in the next Texas Budget, but There's Little Data on What's Being Done with the Money." *The Texas Tribune*, The Texas Tribune, 8 June 2021, https://www.texastribune.org/2021/06/08/texas-abortion-budget/.
[13] Miller, Sid. HB 15, 82nd Regular Session, *Texas Legislature Online - 82(R) Text for HB 15*, https://capitol.texas.gov/billlookup/Text.aspx?LegSess=82R&Bill=HB15.

HB 2 in *Whole Woman's Health v Hellerstedt*.[14] Eventually, the case made its way to the Supreme Court, where the admitting privileges and ambulatory surgical center requirements were deemed unconstitutional. Since 2015, Texas Republicans have passed an additional six pieces of legislation intended to stigmatize abortion care, pressure physicians into choosing to not perform the procedure, and, above all, erode a person's Constitutional right to access abortion, free from government interference. The restrictions include creating additional barriers for minors seeking abortion care and banning insurance companies from covering the procedure in their comprehensive health insurance plans, thus requiring people to purchase separate coverage for abortion care.[15] This year, the Texas Legisalture enacted further restrictions that will drastically reduce access to medication abortions - Senate Bill 4 (SB4) which, among other things, prohibits medication abortion beyond 49 days, despite current FDA safety guidelines that state the medicine can be used up to 70 days, and requires unrealistic reporting requirements for physicians. SB4 also punishes the prescribing physician with a state jail felony if they violate the law. Finally, just a few weeks before SB8 went into effect, the 5th Circuit Court of Appeals became the first federal court in the U.S. to uphold a ban on the standard method of abortion after about 15 weeks of pregnancy- dilation and evacuation commonly known as D&E.[16]

Each of these restrictions has only made accessing abortion care more difficult and dangerous to obtain, especially for the most vulnerable.[17] This is despite the fact that, according to data provided by HHSC, abortions continue to be among the safest procedures in Texas. In the 13 years it has been collecting data, the state has seen had one death from an abortion related complications.[18] In 2013, the Texas Legislature created the Maternal Mortality and Morbidity Review Committee (MMRC) within the Texas Department of State Health Services (DSHS) to study and provide recommendations regarding the high rate of maternal mortality among Texas

[14] "Whole Woman's Health v. Hellerstedt." *Oyez*, www.oyez.org/cases/2015/15-274. Accessed 26 Sep. 2021.
[15] "A Recent History of Restrictive Abortion Laws in Texas." *ACLU of Texas*, ACLU of Texas, 20 Sept. 2021, https://www.aclutx.org/en/recent-history-restrictive-abortion-laws-texas.
[16] 5th Circuit Court of Appeals. *Whole Women's Health v Paxton*. 18 Aug. 2021.
[17] Norwood, Candice. "Texas Law's Use of Surveillance Could Further Harm People of Color." *The 19th*, The 19th, 14 Sept. 2021, https://19thnews.org/2021/09/texas-abortion-law-people-of-color/.
[18] "ITOP Statistics." *Texas Health and Human Services*, https://www.hhs.texas.gov/about-hhs/records-statistics/data-statistics/itop-statistics.

mothers. The MMRC has provided the Legislature with a biennial report detailing the barriers facing pregnant people, the contributing factors to maternal mortality, and a list of policy recommendations intended to address their findings. Their most recent report indicated that in 2013 nearly 40% of the deaths they reviewed were pregnancy-related and 43 percent were pregnancy-associated but not related.[19] Of the pregnancy-related deaths, 31 percent were among Non-Hispanic Black women and 26 percent among Hispanic women. Whereas, that same year, only 11 percent of live births were among Non-Hispanic Black women and 48 percent were among Hispanic women. Unfortunately, this disparity is not new or surprising data in Texas because a common theme across reports and recommendations is the need to address health inequalities and disparities amongst communities of Black, Indigenous, and people of color (BIPOC) by increasing access to quality health education and services. While the Legislature has made some progress to address this critical issue, not nearly enough has been done to solve the problem and the situation has arguably been made worse by restricting access to quality women's health providers.

Senate Bill 8's Impact on Texas

In the years leading up to the passage of SB8, Texas Republicans have worked methodically to reduce access to reproductive health care throughout the state, including abortion care. We can confidently predict the number of unwanted pregnancies in the state will only increase causing a ripple effect throughout society and the state. And as we saw in the wake of HB2, there is a real threat that abortion clinics will close for good. As a result of the past anti-abortion pieces of legislation, the number of abortion clinics in the state has declined from 41 to 22.[20] Within days of SB8's implementation, three of the four Planned Parenthood clinics in San Antonio, one of our nation's and our state's largest cities, decided to stop offering abortion care for the time

[19] Maternal Mortality and Morbidity Review Committee, 2020, *Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report*, https://www.dshs.texas.gov/legislative/2020-Reports/DSHS-MMMRC-2020.pdf. Accessed 29 Sept. 2021.
[20] Hurley, Lawrence. "Impact of Texas Clinic Law at Issue in Abortion Case before Supreme Court." *Reuters*, Thomson Reuters, 1 Mar. 2016, https://www.reuters.com/article/us-usa-court-abortion/impact-of-texas-clinic-law-at-issue-in-abortion-case-before-supreme-court-idUSKCN0W35H5.

being.[21] As more providers are forced to stop providing critical abortion care, the strain on the few abortion clinics left will only increase and leave larger parts of the state dependent on a handful of clinics or providers. For example, the Rio Grande Valley, which is home to around 1.3 million people and spanning about 4,250 square miles, is considered an abortion desert, meaning the majority of residents have little to no access to an abortion clinic.[22] In fact, Whole Women's Health in McAllen is the only clinic in the region. The next closest clinics are in San Antonio (a minimum four hour drive away) and Mexico City (a two hour plane ride or six hours by car). Limited access to abortion care is not the only barrier. If an undocumented immigrant is forced to travel outside of the Valley to receive care, they would have to pass through at least one of the 20 Immigration and Customs Enforcement (ICE) checkpoints and risk deportation. For undocumented Texans, Whole Women's Health is their only option. Otherwise they risk detention and deportation or are forced into parenting. If a patient is able to schedule their abortion, their procedure could cost upwards of $800, or $300-400 more than in other parts of the state.[23] This high cost of care makes accessing the procedure all but impossible in one of the poorest areas of the state.[24]

SB8 not only bans abortions after six weeks gestation, but it also empowers anti-abortion vigilantes to abuse our judicial system for their own personal gain. The bill's private cause of action allows anyone, from anywhere, to come into our state and sue anyone who aids or abets, or intends to aid or abet, in the performance of an abortion after any embryonic cardiac activity is detected. If the plaintiff is successful, the law guarantees them a minimum of $10,000 in

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[21] Bohra, Neelam. "Fearful of Being Sued under New Law, Three of Four San Antonio Abortion Facilities Stop Offering the Procedure." *The Texas Tribune*, The Texas Tribune, 7 Sept. 2021, https://www.texastribune.org/2021/09/07/texas-abortion-law-san-antonio/.

[22] Vagianos, Alanna. "Undocumented and in Need of an Abortion in Texas' Rio Grande Valley." *HuffPost*, HuffPost, 18 Oct. 2021, https://www.huffpost.com/entry/undocumented-abortion-texas-rio-grande-valley-sb8_n_616878a5e4b028316c9363
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[23] "After New Law, a Look inside One of South Texas' Last Abortion Clinics." *The 19th*, 28 Sept. 2021, https://19thnews.org/2021/09/new-law-inside-south-texas-abortion-clinic/.

[24] *U.S. Census Bureau Quickfacts: Rio Grande City City, Texas*, https://www.census.gov/quickfacts/fact/table/riograndecitycitytexas/POP060210.

damages in addition to attorney's fees. At its core, the private cause of action is a deviant scheme to avoid judicial review and circumvent the system of governance our Founding Fathers created. In this way, SB8 is more than just another anti-abortion piece of legislation - it threatens the fabric of our nation by challenging our judicial system, our democracy, and our Constitution. After ten years of court battles, the anti-abortion movement has finally found a piece of legislation that avoids the normal avenues for government intervention. The 6-week Ban is unlike anything we have ever seen and must not be allowed to become the new normal in the United States.

On August 31, Whole Women's Health in Fort Worth performed 67 abortion procedures in 17 hours.[25] From the moment they opened their doors at 7 am, their lobby was full of Texans hoping to exercise their right to have an abortion before SB8's deadline. Even before the bill went into effect, every patient accessing abortion care was required to have an ultrasound, even if not medically necessary; to be given medically-inaccurate misinformation about supposed "risks" associated with abortion; and wait 24 hours before they could have their procedure. Only after completing all of these steps, none of which convey any medical benefit, would the state of Texas allow them to have an abortion. But now, for those patients who are past the 6-week mark and arrive at the clinic for their first appointment, the outcome is very different. For some Texans, arriving even the day before the law went into effect was already too late. *The 19th* shared the story of a Texan who arrived at the clinic on August 31 for her first appointment hoping she would be able to receive an abortion. The young woman, already a mother of three, was set to begin a five-year prison sentence later that week and did not want to give birth in jail. However, when she arrived at the clinic for the first appointment she was found to be 12 weeks pregnant. Despite being well within the Constitutional limit for abortion, the clinic had to turn her away because she would be too far along to get the procedure on September 1, which would have been the soonest she could have had the abortion due to the mandatory 24 hour waiting period. Upon hearing the news, the woman broke down in tears and begged the clinic to give her care. She was desperate and facing the possibility of carrying a child to term while

[25] Carrazana, Chabella. "67 Abortions in 17 Hours: Inside a Texas Clinic's Race to Beat New Six-Week Abortion Ban." *The 19th*, The 19th, 2 Sept. 2021, https://19thnews.org/2021/09/abortion-texas-whole-womans-clinic/.

incarcerated. Another clinic shared the story of a Texas woman who went to her first appointment on August 31 at which time there wasn't a heartbeat detected on the state mandated sonogram.[26] However, 24 hours later, on September 1, she arrived for her second appointment to actually have the procedure and her physician performed the second sonogram to verify there wasn't any cardiac motion, and to her horror there was an audible 'whoosh whoosh' sound coming from the machine. At only five weeks, she was too late to receive an abortion under the provisions of SB8. She was devastated. She already had a child at home and knew that bringing another child into their lives threatened her family's newfound financial security. In both of these situations, having an abortion was the right decision for their life and their family's well being, but arbitrary and unnecessary government interference denied them the ability to make that decision for themselves and their families.

If a person wants to terminate their pregnancy after the Texas deadline has passed, they must find other ways to do so. For nearly 80% of Texans seeking an abortion, accessing abortion out of state is the best option, even though it may take a drive of six to twelve hours each way to reach the closest clinics.[27] And neighboring states still have their own restrictions. Oklahoma, for example, has a required 72-hour waiting period between the first visit and the procedure. Even still, providers in Oklahoma and New Mexico have reported an exponential increase in the number of Texas patients receiving care at their clinics in just the four weeks that SB8 has been in effect. Trust Women Clinic in Oklahoma had 11 Texas patients in August; as of this week they have seen well over 100 since September 1.[28] Planned Parenthood Rocky Mountains in New Mexico has seen, and scheduled, more than triple the number of Texas patients they saw before the law went into effect.[29] For some Texans, traveling out of state is simply not an option.

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[26] Tavernise, Sabrina. "With Abortion Largely Banned in Texas, an Oklahoma Clinic Is Inundated." *The New York Times*, The New York Times, 26 Sept. 2021, https://www.nytimes.com/2021/09/26/us/oklahoma-abortion.html.
[27] White, Kari, et al. "The College of Liberal Arts the University of Texas at Austin." *UT College of Liberal Arts: TxPEP*, July 2021, https://liberalarts.utexas.edu/txpep/research-briefs/senate-bill-8.php.
[28] Tavernise, Sabrina. "With Abortion Largely Banned in Texas, an Oklahoma Clinic Is Inundated." *The New York Times*, The New York Times, 26 Sept. 2021, https://www.nytimes.com/2021/09/26/us/oklahoma-abortion.html.
[29] Nottrnott@sfnewmexican.com, Robert, and Jim Weber/The New Mexican. "New Mexico Abortion Clinics See Influx from Texas." *Santa Fe New Mexican*, 19 Sept. 2021, https://www.santafenewmexican.com/news/local_news/new-mexico-abortion-clinics-see-influx-from-texas/article_68e114a6-14bc-11ec-9060-6bf8aaa0e8cc.html.

Between the costs of transportation, lodging, child care, and the risks to their jobs if they don't have paid family leave, Texans with low incomes are left without options.[30] Immigrants, people with disabilities, and young people struggle with multiple barriers that do not allow them to seek care out of state.

SB8 does not only negatively impact Texans seeking abortion care; this bill has reverberated throughout the medical community. During the 87th Regular Session, physician groups such as the American College of Obstetricians and Gynecologists openly and adamantly opposed this bill. ACOG stated, "As ob/gyns, we take pride in the care we provide women in the most difficult of times and support the provision of unbiased counseling for informed consent for medical procedures. However, SB8 does not provide this. SB8 is an unnecessary intrusion in the physician-patient relationship and compromises compassionate conversations between doctors and patients."[31] This bill forces physicians to make an impossible decision - choose to do what is in the best interest of their patient or risk being sued for tens of thousands of dollars. In just a few short weeks, every legislative office has heard the outrage of the medical community. By opening them up to civil and criminal penalties, Texas doctors feel as though the Legislature has abandoned them. Recently, Dr. Charles Brown, a local doctor and professor at the University of Texas Southwestern School of Medicine, recounted the issues he and other medical school professionals are facing in regard to this bill. He stated that SB8 has called into question their ability to practice and teach medicine accurately and according to best practices. He said many are still unclear as to what they can do when it comes to situations in which the life of the mother is not in imminent danger, but carrying the pregnancy to term is not their best option. He stated that many in this kind of situation are left without treatment options and feel they are "waiting for women to die."

Conclusion

[30] Supreme Court of the United States. *Thomas E. Dobbs, State Health Officer of the Mississippi Department of Health v. Jackson Women's Health Organization.*
[31] Dunn, Tony. "Texas-ACOG Opposes HB 1515 by Representative Slawson and SB 8 by Senator Hughes." The American College of Obstetricians and Gynecologists. Accessed 27 Sept. 2021.

TEXAS HOUSE
WOMEN'S HEALTH CAUCUS

Texas has methodically and incrementally imposed more and more barriers to accessing abortions, culminating in the passage of SB8, a de facto ban on abortion, enforced by private citizens without standing. Texans are now being denied their constitutional right to abortion healthcare without judicial protection. The repercussions to women's health, freedom over one's own body and destiny, as well as to constitutional protections will have far-reaching impacts. Texans seeking abortion care do not have the luxury of time; the architects of SB 8 purposefully designed a law to avoid an immediate injunction and without any regard to the impact it would have on the lives of the people it affects. The 6 Week Ban is a cruel and unconstitutional piece of legislation that forces Texans seeking abortion care and Texas doctors into impossible situations. Everyday this law is allowed to remain in effect, Texans who are unable to terminate their pregnancy as a result will be forced to decide between parenthood and adoption. We may not agree on the issue of abortion, but certainly we can agree the state should not be trying to enforce healthcare regulations by inviting out of state activists to use our court system to harass doctors and other healthcare providers in Texas. Congress must protect abortion access and pass the Women's Health Protection Act. This right, as others, should not be subject to state boundaries and court decisions but, rather, should be guaranteed for all Americans. Thank you again for the opportunity to submit written comments. If there are any questions, please do not hesitate to reach out to our Executive Director, Kristen Ylana, at kristen.ylana@house.texas.gov. We look forward to working with you to ensure every American has access to the healthcare services they need.

Sincerely,

Donna Howard

State Representative Donna Howard
Texas Women's Health Caucus, Chairwoman

TEXAS HOUSE
WOMEN'S HEALTH CAUCUS

Alma Allen
State Representative

Elizabeth "Liz" Campos
State Representative

Rafael Anchia
Chairman, Mexican American Legislative Caucus
State Representative

Garnet Coleman
Chairman, Legislative Study Group
State Representative

Diego Bernal
State Representative

Nicole Collier
Texas Legislative Black Caucus, Chairwoman

Rhetta Bowers
State Representative

Jasmine Crockett
State Representative

John Bucy
State Representative

Jessica Gonzalez
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Bobby Guerra
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Gina Hinojosa
State Representative

Celia Israel
State Representative

Ann Johnson
State Representative

Julie Johnson
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Trey Martinez-Fischer
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Ina Minjarez
Whip, Texas Women's Health Caucus
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Claudia Ordaz Perez
State Representative

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State Representative

John Turner
State Representative

Toni Rose
State Representative

Gene Wu
State Representative

Erin Zwiener
State Representative

James Talarico
State Representative

Shawn Thierry
State Representative

Chris Turner
Chairman, House Democratic Caucus
State Representative

Chair NADLER. [Presiding] Without objection.

Ms. ESCOBAR. Thank you.

Chair NADLER. The gentlelady's time has expired.

Ms. Ross.

Ms. ROSS. Thank you very much, Mr. Chair, and thank you so much to the Witnesses for their patience and for your dedication to the women of Texas and the women of this country. I want to start with a couple of quotes from Justice Ginsburg I know our Chair started, but I think it is a nice way to remind us of why we are here today and why this Texas law is so pernicious.

I want to remind the Committee of what Justice Ruth Bader Ginsburg wrote in her 2007 dissent in *Gonzalez* v. *Carhart*:

> Legal challenges to undue restrictions on abortion procedures do not seek to vindicate some generalized notion of privacy. Rather, they center on a woman's autonomy to determine her life's course and, thus, to enjoy equal citizenship statute.

Justice Ginsburg argued this point in her 1993 Senate confirmation hearing as well, explaining that the decision whether or not to bear a child is central to a woman's life, well-being, and dignity. It is a decision she must make for herself. When the Government controls that decision for her, she is being treated less than as a fully adult human responsible for her own choices.

This holds true today, and these same issues are under threat and women are under threat. Senate Bill 8 is appalling for many reasons, including its unconstitutionality and the deputization of private citizens as bounty hunters. Our focus must be on the simple fact that this is a law that hurts women.

In the end, that is the only thing that matters. Forced parenthood threatens a woman's physical and mental health. It restricts our economic freedom. It makes women of color poorer, and, in particular, second-class citizens. There is plenty of data that you have shared with us that support these findings.

The only proof we really need that these laws—this law hurts women—come from the stories you have shared today. I want to go back to what we just heard from Dr. Moayedi, and I love the point that you were making, that if we are truly, truly pro-family, then we need to enact policies that make it easier for people who have children to give those children a good life.

That involves the health and healthcare of women. In Texas, like in my home State of North Carolina, there has not been Medicaid expansion. That means that women are not able to get critical healthcare preconception and take care of themselves, and not able to get health services postpartum when they are trying to care for a new baby.

So, Doctor, please share with us how Texas' decision to deputize people to prevent abortions runs contrary to a woman's health when Texas cannot find it in its heart to provide Medicaid to poor women.

Dr. MOAYEDI. Thank you for that question, Representative Ross. It brings to mind a story of a patient I took care of several years ago. This person was a mother of five or six children—I can't remember at this point—but had several children and had recently had a child as well. She developed severe heart failure after that

pregnancy and was just told, "Don't become pregnant again; you will die."

Well, in Texas, prior to this last session, your Medicaid expired at six weeks. So, there was no way for her to get her cardiac drugs. There was no way for her to get birth control afterwards to keep herself healthy. Of course, she became pregnant again, and continuing that pregnancy would have killed her.

So, this person, a mother of many children, struggling to be a good mom, had to scrape together everything to be able to get abortion care so she wouldn't die and leave her children without a parent.

I deal with those situations every single week in Texas. We need better healthcare in our State desperately, and that includes removing restrictions to abortion care and expanding Medicaid.

Ms. ROSS. Thank you so much for helping women.

I yield back.

Chair NADLER. The gentlelady yields back.

The gentlelady from Texas is recognized for a unanimous consent statement.

Ms. JACKSON LEE. Mr. Chair, I would like to ask unanimous consent to submit into the record articles, "These Texas women got abortions from a California doctor after the State's ban. Here are their stories." *The San Francisco Chronicle*; "Texas Abortion Law Could Worsen the State's Maternal Mortality Rate," *New York Times*; September 22, 2021; "Texas abortion: Doctor sued in first-known challenges of new law," *BBC News*, September 21, 2021; "'My body is not their property': Texas woman's journey across state lines for an abortion," October 15, 2021; and finally, "Opinion | Why I violated Texas's extreme abortion law," *Washington Post*, September 18, 2021.

I ask unanimous consent to submit these into the record.

[The information follows:]

MS. JACKSON LEE FOR THE RECORD

A

These Texas women got abortions from a California doctor after the state's ban. Here are their stories

OKLAHOMA CITY — Ianthe Davis ended her bartending shift at 4 a.m. one recent morning in Dallas. An hour later, a friend picked her up and drove her three hours up Interstate 35 to this capital city so she could get an abortion — a procedure that became almost impossible to obtain in her home state of Texas after a new law went into effect this month.

At a clinic in Oklahoma City, Davis was treated by another woman who was far from home, Dr. Rebecca Taub. The obstetrician and gynecologist travels once a month from her home in the East Bay to the small clinic, where she performs dozens of abortions over the course of two days.

After the procedure, Davis and her friend turned around and drove home. As a bartender, Davis said, "If I don't work, I don't make money."

A Texas woman, an Oklahoma clinic and a California doctor: The scene offered a snapshot of the landscape under the Texas law that bans nearly all abortions after an embryonic heartbeat is detected — usually around six weeks — and makes no exceptions for rape, sexual abuse or incest.

The new law also enables private citizens to sue anyone who either performs an abortion or "aids and abets" one — and collect $10,000 plus their legal fees if they win the case. The law has narrow exceptions to protect the life of the mother or if continuing a pregnancy would cause "substantial and irreversible impairment of a major bodily function."

Ianthe Davis, 27, who traveled three hours from Dallas, lies still during an ultrasound at the Trust Women clinic in Oklahoma City. Davis was six weeks pregnant and unable to get an abortion in her home state, so she was forced to drive to Oklahoma. Gabrielle Lurie/The Chronicle

The Chronicle spoke to several women on a recent weekend who traveled from Texas to a one-story, mustard-brick building in suburban Oklahoma City called the Trust Women clinic, where Taub has been working.

Clinic officials said they have seen a roughly 50% increase in patients overall since the new legislation took effect, including 110 women from Texas over the past seven days. That is as many as visited the clinic during all of August.

The length of Davis' journey is not unusual. Before the ban, the average woman of childbearing age in Texas lived 17 miles from the nearest abortion provider, according to the Guttmacher Institute, a research organization that supports abortion rights. Now, the average driving distance is 247 miles.

The Texans most affected by the new law will be women of color, who constitute 70% of those who received abortions in 2019, according to Guttmacher.

Abortion access is so limited in Dallas, the nation's ninth-largest city, that Davis contacted a clinic there before the law took effect this month but was turned away. "They said they wouldn't be able to" perform the procedure, she said. Demand for the clinic was so strong that she would have been 14 weeks pregnant by the time an appointment was available.

The new law confused Davis. She feared telling many people about her situation "because if you do, you might get charged or something like that. I know there are $10,000 rewards for people" who supply information about women obtaining abortions, she said.

She had heard of clinics in Arkansas and New Mexico that were seeing patients, but Trust Women was closer. When she arrived in Oklahoma City, she was just a few days over six weeks pregnant.

Dr. Rebecca Taub performs a surgical abortion at the Trust Women clinic in Oklahoma City. Taub, an OB-GYN specializing in family planning, travels once a month to the clinic in Oklahoma to perform both surgical and medical abortions. Gabrielle Lurie/The Chronicle

Davis said she understands placing limits on abortion. Roe vs. Wade, the 1973 Supreme Court ruling that provided women the right to have an abortion, permits the procedure until about 24 weeks, when the fetus can survive outside the womb.

"I do understand putting a limit, I get that part," said Davis, 27. "Most people don't find out because it's like, soon as hell. And then there are

people who were raped."

Davis had a supportive family and a friend willing to drive her to a clinic. But she said she knows other Texas women who, because they can't afford to travel out of state, are trying scientifically dubious methods of pregnancy termination that are popular online, like taking large amounts of vitamin C.

"But that just didn't sound that effective to me," she said. "So I made the drive."

She worried about the extreme measures that others confronting unwanted pregnancies might attempt.

"It's probably gonna get bad," Davis said. "I mean, I heard one girl tried to drink bleach."

The U.S. Justice Department sued the state of Texas to try to block the abortion law, saying it violates women's constitutional rights by creating an "undue burden" on those who want to have an abortion. A hearing is scheduled for Oct. 1 in Texas.

Until then, a steady stream of women like Davis will continue coming to the Trust Women clinic, where they will be greeted by doctors like Taub.

Left: A poster on the wall of the locker room in the Trust Women clinic in Oklahoma City. Trust Women is one of the few clinics in Oklahoma to perform abortions. It is difficult for the clinic to find local doctors who will perform the procedure, so several physicians from other states make monthly trips there. Right: A stack of ultrasound images sits on a desk at the Trust Women clinic in Oklahoma City. Gabrielle Lurie/The Chronicle

The 35-year-old East Bay obstetrician and gynecologist, clad in blue surgical scrubs, performs roughly two dozen abortions a day when she is in town because it is difficult for the clinic to recruit local doctors, a common situation in states where the procedure is culturally shunned and women are required to scale many hurdles to obtain one.

To Taub, this is a form of activism. After seeing out-of-state patients and calls to the Oklahoma City clinic swell after the Texas law passed — two-thirds of the calls to the clinic inquiring about services are now from the neighboring state — she wants to do more.

On this day, the waiting room was full of women seeking services they couldn't find close to home. The clinic's halls and waiting rooms were full of affirming messages, including posters saying, "We Love You!" "Everyone Loves Someone Who Had an Abortion" and "Prove Them Wrong."

"There's an urgency to the work that people who work with the clinic follow because they're activists and they believe in this work," Taub said. Since the Texas law took effect, her work "has definitely taken on a new urgency."

The people who work at the clinic see the urgency in the faces of women like Daffnay McCoy. She, too, had an appointment for an abortion scheduled in Dallas. But she said that when the law took effect, clinic providers there explained that things had changed: They could give her a sonogram, they said, but wouldn't perform an abortion.

After traveling three hours from Dallas, Daffany McCoy, 28, rests in the recovery room after getting a surgical abortion at the Trust Women clinic in Oklahoma City. Gabrielle Lurie/The Chronicle

"It kind of kind of freaked me out." McCoy said. "I got hysterical and started panicking. I was hallucinating like I was going crazy."

She said she has suffered from depression in the past and was worried that not being able to secure an abortion "was about to bring me back to that dark place."

McCoy was already so stressed by her job in the payroll department for a Texas company, she said, that she had been suffering minor seizures. She has two children and felt she wouldn't be able to adequately care for another. She said she is no longer with the father of her two children — who also impregnated her most recently — though he drove her to the clinic along with their children.

McCoy said she wouldn't have known she was even pregnant if she hadn't gone to the hospital because she was ill.

"But at that time, I was already past six weeks," she said.

Once she arrived in Oklahoma City, wearing a T-shirt that said "Fierce and Fabulous," she said she summoned an inner strength. She wished people who wrote the Texas law — or those who criticize women for

having abortions — would be more empathetic toward women with unwanted pregnancies.

"You don't know how this life came about. You don't know if someone has been raped. Or if someone is going through an illness or a mental(ly unstable) state of mind. You just never know," she said. "So to be on the safe side. I just feel as though no one should be obligated to make decisions for another individual. It just doesn't make sense."

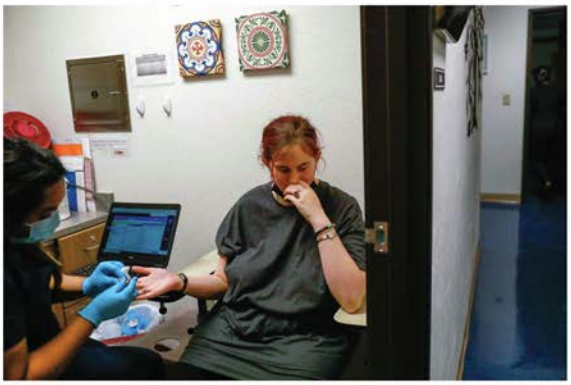
Judith said she felt the same way. The 33-year-old nurse's assistant, who asked that her last name not be used because she does not want her family to know about her abortion, was five weeks along when she learned she was pregnant — too far along to find a clinic that could accommodate her before the onset of the law's time limits.

She left her home in Houston at 6:30 a.m. so she could arrive at the Oklahoma City clinic in time for her surgical procedure. She completed the 6½-hour drive alone, but said it "wasn't bad. I prayed. And I listened to my gospel music."

It was worth it, she said, because she didn't feel healthy enough to have another child. She has diabetes, and her partner has kidney problems that will soon require dialysis. Plus, she already has four children.

"We both are sickly people. We're just not well," Judith said. "If anything happens to us, who's gonna take care of our baby?"

Courtney, who also asked to be identified only by her first name, drove three hours to the clinic from a small town near Dallas. She was eight weeks pregnant.



After traveling more than three hours from Grandview, Texas, Courtney, 20, waits to obtain a medication abortion at the Trust Women clinic in Oklahoma City. Of visiting abortion clinics in Texas, she said "All of them said they wouldn't do it because the heartbeat bill passed and saying that it was too risky. It was extremely stressful. The reason I'm actually getting an abortion is that I'm worried about what it would do for my mental health and my physical health and my relationship with the rest of my family. I recently found out I have seizures. When I got pregnant it started happening more and more. I'm scared that being pregnant while having seizures would end my life." Gabrielle Lurie/The Chronicle

The 20-year-old's reasons for seeking an abortion were both personal and medical. She feared that if her devoutly Catholic family learned she was pregnant and unmarried, "they would isolate me from the rest of the family. So going to term with this is not an option for me."

She also has a medical condition that causes seizures, which had increased since she became pregnant. "And so with that I'm scared that being pregnant while having seizures could end my life," she said.

She tried to find a clinic in Texas, but "all of them said that they wouldn't do it because of the heartbeat bill," she said.

Adding to her stress was a clutch of anti-abortion demonstrators beyond the 6-foot-high wooden picket stockade fence that surrounds the Oklahoma City clinic. As she walked inside, she said she heard

them say, "You're committing murder. You're sinning. If you need money, or a prayer, we can help. Your baby can be put up for adoption."

"I'm sitting there having to bite my tongue. Literally having to bite my tongue to keep from speaking," she said. "My arms are shaking, my hands are shaking, not even able to ignore them, because my emotions were being stirred up."

Trust Women clinic officials are expecting the flood of Texas women driving north to grow. They're considering expanding their hours and adding staff, and are trying to recruit more doctors like Taub — even if they have to pay to fly them into town. On Nov. 1, a similar fetal heartbeat bill is scheduled to take effect in Oklahoma. Abortion rights organizations are attempting to block it.

Since the Texas ruling, Taub said some of her California colleagues have asked her about traveling to clinics like she does.

But she has more immediate concerns about her patients once they leave Oklahoma and drive home to Texas.

"There are so many unknowns in how this law can and will be enforced that I am concerned that pharmacists in Texas may not fill prescriptions that they know come from an abortion clinic, even though they are not the medications that are going to enact the abortion," Taub said, referring to ibuprofen and anti-nausea medication she prescribes.

Her advice to patients before they head back to Texas: "I told them that they had to fill their prescriptions in Oklahoma."

Volunteer Jennifer Goodner helps patient Judith, 33, in a wheelchair after a surgical abortion at the Trust Women clinic in Oklahoma City. Judith had to travel more than six hours from Houston to get the procedure. Judith suffers from Type 1 diabetes and her partner, with whom she shares four kids, suffers from kidney failure. " I am sick. Why would I want to bring kids into this world? I know that if I'm gone no one can mother them like I do," she said. Gabrielle Lurie/The Chronicle

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Texas' Abortion Law Could Worsen the State's Maternal Mortality Rate

Abortion rights protesters march outside the Texas State Capitol in Austin on Sept. 1. Texas passed S.B. 8, which bans nearly all abortions and it went into effect Sept. 1.
Sergio Flores—The Washington Post/Getty Images
September 22, 2021 7:00 AM EDT

Texas' controversial six-week abortion ban has been in effect just 21 days, and physicians and researchers are already warning that the impact could be dire: if the law remains in effect, Texas could see a significant increase in maternal mortality.

A new analysis from Dr. David Eisenberg, a board certified obstetrician-gynecologist who provides abortions in Missouri and Illinois, estimates that with the new law in effect, the state could see increases in maternal mortality of up to 15% overall, and up to 33% for Black women next year. The estimate is based on previous research that has established a clear link between abortion restrictions and maternal mortality. Black patients are often disproportionately

impacted by abortion restrictions, and they are far more likely to die in to pregnancy-related deaths than white or Hispanic women.

"When you eliminate the ability for people who become pregnant to decide what's best for them and their health and their family, it has a negative impact on the health of themselves, as well as their families and the communities they come from," says Eisenberg, the former

medical director of Planned Parenthood of the St. Louis Region and Southwest Missouri.

The Texas law, known as Senate Bill 8, prohibits abortion once an ultrasound detects cardiac activity. In practice, that means that no one in the state can provide an abortion after roughly six weeks into a pregnancy, which is before many people discover they are pregnant. In addition to the law's impact on patients, its extreme limit could also cause many abortion clinics to close their doors, which would further reduce access to care for state residents.

While the Texas law is unprecedented in its private enforcement mechanism, many other states have passed limits on abortion in recent years, and researchers have shown that these are associated with negative health outcomes. In a study published in March in the journal *Contraception*, Eisenberg and his co-authors found that from 1995 to 2017, the maternal mortality rate increased most significantly in states that enacted the most restrictive abortion laws. In 2017, states that restricted abortion had a maternal death rate (28.5 maternal deaths per 100,000 live births) that was nearly double (15.7 maternal deaths per 100,000 live births) those that had passed laws protecting access to abortion.

In another study, published in the *American Journal of Preventive Medicine* in 2019, researchers looked at maternal mortality data from 38 states and Washington, D.C. and found that gestational limits on abortion and Planned Parenthood clinic closures each significantly increased maternal mortality. They found that laws restricting abortion based on gestational age increased maternal mortality by 38% and that a 20% reduction in Planned Parenthood clinics increased a state's maternal mortality rate by 8%.

Since the study was based on statistical analyses of state-level data, researchers could not look at complicating factors for each individual patient. But Summer Sherburne Hawkins, the study's lead author and an associate professor at Boston College's School of Social Work, says the analysis shows the direct impact of abortion restrictions like the one in Texas.

"Based on our research, restricting abortion based on gestational age, as has been done in Texas, will likely have detrimental effects on women's health," she says. "It could have increases in maternal mortality."

Eisenberg's new analysis builds on this idea and pulls from his previous research published in *Contraception*. He found the Global Health Data Exchange showed a 6% increase in maternal mortality in states that restricted abortion access relative to neutral states. The CDC WONDER database showed a 24% increase in states that restricted abortion access relative to neutral states. The median increase, 15%, is what he predicts could take place in Texas if its current abortion law remains in place.

Abortion providers in the state are already seeing patients who they fear could end up in dangerous circumstances. Dr. Bhavik Kumar, a staff physician at Planned Parenthood Center for Choice in Houston, says the law has forced him to turn away patients who will likely not be in a place to have a healthy pregnancy. Planned Parenthood has become a "traffic control" center with care coordinators helping people find resources to travel out of state for care or explore other options, he says. But not all patients can travel long distances to receive care.

Kumar says he saw a patient last week who is navigating a meth addiction and is homeless, who he doubts will be able to travel out of state to get an abortion. Another of his patients already has seven children, one of whom is in the hospital with a terminal illness. She likely will not be able to leave the state—and her children—to get an

abortion either, but she also knows she will struggle to take care of another child, Kumar says.

The Texas law means these patients must make incredibly difficult choices as they seek care. If they cannot obtain abortions, they may be forced to deal with the mental and physical stress of carrying unwanted pregnancies to term.

"There's also consequences with morbidity, meaning people having more complicated pregnancies that take a toll on their health, having more complications, and having a lower quality of life," Kumar says. "And that's not just for them. It's also for their families and the children that they are forced to have."

The U.S. faces a crisis of maternal mortality

The new Texas law is the latest in a wave of restrictions on abortion nationwide. For more than a decade, largely conservative states like Texas that have steadily implemented a series of laws and regulations making it more logistically and financially difficult for women to access all kinds of reproductive health care. Even amid this trend, Texas stands out as one of the most challenging places to obtain an abortion and to give birth to a child.

The U.S. has faced a crisis of maternal mortality for years. It has the highest rate of maternal mortality in the developed world, and the country's numbers have worsened significantly over the last 30 years, according to a new report the U.S. Commission on Civil Rights released Sept. 15. This is in large part due to growing disparities in access to quality care for women of color. "As an individual, as a Texan, I'm appalled that, at a time where we need stronger hospitals and a higher quality of hospital care for Texans, we're going in the wrong direction," Norma Cantú, chair of the Commission on Civil Rights, said in response to a question from TIME last week.

The maternal mortality rate in Texas is already higher than the U.S. average, and Black women bear the brunt of this tragedy: they

account for just 11% of live births, but make up 31% of maternal deaths in the state. In 2013, Texas created an expert committee to examine this issue. It found that many of the maternal deaths in Texas are preventable and recommended that the state extend health insurance coverage for poor mothers to one year after they have a baby. But lawmakers have not done that. Instead, in May the state passed a law extending Medicaid coverage for six months after childbirth.

Texas has the highest rate of uninsured residents in the country, the highest rate of uninsured women of childbearing age, and its leaders have refused to expand Medicaid under the Affordable Care Act, which would have allowed more low-income Texans to access the public health insurance program. Texas also has the strictest income limit for Medicaid eligibility in the country: a single Texan parent with three children must earn $277 or less a month to be eligible. During pregnancy, that cap increases to $4,373.

The new Texas abortion law is being challenged in court. The Department of Justice has asked a federal judge in the Western District of Texas to block the law while it sues Texas, and the next hearing is set for Oct. 1. But even if the law is temporarily blocked, it is written in a way that could make it difficult for abortion providers to resume their regular work until they have a final verdict.

The effects of even a temporary ban are likely to reverberate. When Texas enacted a law in 2013 that required abortion clinics to obtain admitting privileges at local hospitals and imposed other restrictions, half the clinics in the state closed. Even after the Supreme Court ruled that law unconstitutional in 2016, few clinics returned. As a result, huge swaths of the state became abortion deserts. Under the new law, the average Texan must drive 14 times farther than they had to previously to access an abortion.

In recent weeks, lawmakers from other conservative states have said they see Texas as a model and hope to pass similar legislation, and in December, the conservative Supreme Court is scheduled to hear a

case about an abortion restriction in Mississippi. While those who oppose abortion are celebrating what they see as a win for their movement, physicians and researchers like Eisenberg—as well as residents in conservative states—say they are bracing for a coming wave of maternal deaths.

More Must-Read Stories From TIME

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Texas abortion: Doctor sued in first known challenges of new law

- Published
  21 September 2021

Image caption, Protests were held against the new legislation outside the Texas State Capitol in Austin

A Texas doctor who admitted to breaking the state's new abortion legislation has been sued, in what could be a test of how lawful the mandate is.

Writing for the Washington Post, Alan Braid said he had carried out a termination on a woman who was in the early stages of her pregnancy but "beyond the state's new limit".

Former lawyers in Arkansas and Illinois filed lawsuits against him on Monday.

The new legislation bans abortions from as early as six weeks into a pregnancy.

The law came into effect on 1 September, giving any individual - from Texas or elsewhere - the right to sue doctors who perform an abortion past the six-week point. However it does not allow the women who get the procedure to be sued.

The law bans terminations after the detection of what anti-abortion campaigners call a foetal heartbeat, something medical authorities say is misleading.

Dr Braid, who has been practising medicine for nearly 50 years, wrote in an opinion column published on the weekend: "I acted because I had a duty of care to this patient, as I do for all patients, and because she has a fundamental right to receive this care.

"I fully understood that there could be legal consequences - but I wanted to make sure that Texas didn't get away with its bid to prevent this blatantly unconstitutional law from being tested," he wrote.

Oscar Stilley, a former lawyer in Arkansas who is serving a 15-year federal conviction for tax fraud in home confinement, said he had decided to file the lawsuit after reading Dr Braid's opinion piece. He said he was not opposed to abortion but sued to force a court to test the legality of the new legislation.

In an interview with Reuters news agency, he said the new restrictions violate women's constitutional rights.

A second lawsuit was filed by Felipe Gomez, from Illinois, who described himself as a "Pro Choice Plaintiff" in the suit and claimed the law was "illegal as written and as applied".

Dr Braid has not commented on the lawsuits, the first known legal challenges to the law which is one of the most restrictive in the country.

Media caption,

From 2019: The US abortion battle explained in three minutes

The "Heartbeat Act" was signed into law by Republican Governor Greg Abbott in May. It took effect after the Supreme Court did not respond to an emergency appeal by abortion providers.

Earlier this month, the US justice department filed an emergency motion, seeking to block enforcement of the law while it pursues legal action.

Abortion providers say the law is at odds with the 1973 Supreme Court decision in Roe v Wade, under which US women have the right to an abortion until a foetus is viable - that is, able to survive outside the womb. This is usually between 22 and 24 weeks into a pregnancy.

The law enforces its ban with an uncommon approach: it empowers any private citizen to sue anyone who "aids and abets" an illegal abortion.

People who successfully sue under the Texas law will be awarded at least $10,000 (£7,200), in addition to any legal fees incurred.

Critics, like the American Civil Liberties Union, have said this leaves the responsibility for enforcing it on individuals, rather than local or state officials, and could give rise to abortion "bounty hunters".

A

'My body is not their property': Texas woman's journey across state lines for an abortion

At 21 years old, Texas college student Madi said she was not ready to be a mother.

She was about 10 weeks along when she found out she was pregnant and decided she wanted to have an abortion.

But due to the new Texas law that effectively bans abortions as early as six weeks into pregnancy, Madi's personal choice turned into an arduous journey, traveling hundreds of miles and crossing state lines for the procedure.

Madi, who asked to only be identified by her first name, traveled out of Texas to receive an abortion in Mississippi. ABC

"I'm drowning," said Madi, who asked to only be identified by her first name. "That's the best word to describe it, drowning."

On Sept. 1, the most restrictive abortion law in the country went into effect. Senate Bill 8 bans abortions once cardiac activity is detected and before some women know they are pregnant. Nearly a month

later, Madi traveled more than 400 miles to the only abortion clinic left in Mississippi.

She says her story reveals the lengths some women face to have a choice.

Madi, who asked to only be identified by her first name, is a college student in Texas. ABC

"I am a senior in college. I just turned 21 and I would say I'm a pretty typical college kid," Madi told ABC News. "I am 13 weeks pregnant right now and I'm not in a place to have a baby."

Madi said she was in a committed relationship and on birth control so her pregnancy was unexpected. She didn't experience any early pregnancy signs until the nine-week mark, which at the time seemed like the typical stress of being a senior and starting a new semester.

"I had been not sleeping and not eating and nauseous for a few weeks," said Madi. "So I took one test and it came out a clear plus sign from the beginning. And I was devastated."

Up until that point, she had been living her life normally, she said.

MORE: Supreme Court allows Texas' controversial abortion ban to take effect

"I was still living my life as regular and as carefree of a college kid as I could be," said Madi.

After several positive pregnancy tests, Madi booked an appointment at a Planned Parenthood in Texas.

She said the clinician told her she was measuring 10-and-a-half weeks into her pregnancy -- past the mark at which she could still receive the procedure in Texas.

"I just cried. I was heartbroken and terrified," said Madi. "I immediately knew that any chance I had of being able to have this procedure done in Texas was gone."

Madi, who asked to only be identified by her first name, lives in Texas. ABC

She immediately knew that she wanted to exercise her federal right to choose, despite the new Texas law.

"There aren't any laws on the books in any state regulating men's bodies. It's sexist, it's unequal and it's wrong," said Madi. "My body is not their property.

Madi said she began to research nearby clinics across state lines. She said she called more than 30 clinics, looking for the earliest open appointment.

"I started researching with the materials that Planned Parenthood gave me and looked into Louisiana and Louisiana's booked out three weeks," said Madi. "I called Alabama, and Kansas, and Oklahoma, and Vegas, and Georgia."

MORE: DOJ files for immediate injunction to halt enforcement of Texas abortion law

The earliest appointment Madi could find in Mississippi was more than 400 miles away.

Jackson Women's Health is Mississippi's last abortion clinic and the center of a potentially historic Supreme Court case that could possibly overturn Roe V. Wade.

Clinic director Shannon Brewer has been working at Jackson Women's Health for two decades. She said the new Texas law isn't deterring people from getting an abortion, only pushing them to travel out of state for the procedure.

Shannon Brewer is the clinic director at the Jackson Women's Health clinic in Mississippi. ABC

"We've been even busier, because now we're seeing even a lot more patients from Texas," said Brewer. "We've almost doubled our capacity. Our phones are ringing non-stop because of this."

Madi said it was with the help of her parents that she was able to get the procedure. Her mother, who asked not to reveal her name, said she wasn't angry at Madi for her situation.

"I'm angry with Governor Abbott," said Madi's mother. "I'm angry that men have decided this is what's best for women."

Madi and her family had to make two separate trips to Mississippi in order to secure her appointment. Madi said she was grateful for the support through such an emotionally difficult time.

"There were so many emotions going on at once that it was a blur. The anxiety was still there. The frustration was still there. And I think honestly just the fear of the unknown," said Madi.

Madi pictured at the Jackson Women's Health clinic in Mississippi. ABC

"I had to keep in mind that I was doing this for me. This is my future on the line. It's my body on the line. And it's a lot to take in," she added.

ABC News followed Madi on the day of the procedure.

Madi said the staff at Jackson Women's Health helped put her mind at ease.

Her nurse walked Madi through what would happen during the procedure.

Madi pictured in the waiting room at the Jackson Women's Health clinic in Mississippi. ABC

Prior to starting, she explained that Madi would first receive medication and then be asked to wait an hour-and-a-half to let her body prepare for the procedure. While she waited, she said her decision did not waiver.

"It's my body and it's my choice," said Madi at the time. "I don't think it's right for people to try and convince others when it's not their life that's about to change."

Madi said she wanted to publicly share her deeply intimate moment to break the stigma around a taboo topic.

"No one talks about this process," said Madi. "I'm glad that I'm able to kind of shine a light and give people a little bit of that sense of control back that I feel like I've been lacking in this process."

She said that the patient before her helped let her know that she wasn't alone.

Shannon Brewer has worked at the Jackson Women's Health in Mississippi for 20 years. ABC

"Waiting for my turn to go into the room was so heavy because you're sitting there knowing that there's a girl in there before you," said Madi. "Watching her come out and seeing that thumbs up from her, that she was doing OK after it, that put a little bit of ease on my nerves."

During the procedure, Madi said she appreciated that she was able to ask questions and that the clinicians talked her through each step. After the procedure was over, Madi fell into her mother's arms crying.

"We got in the car, got buckled, and we started making our way to the airport. Got on the flight and I finally slept," said Madi.

By the time she got home, she learned of a stunning legal development.

On the same day as her procedure, a federal court blocked Texas' Senate Bill 8 -- the law that had forced Madi to go to Mississippi for her procedure in the first place.

"To think that this could all, like, be overturned again and it goes back into place .... really scares me," said Madi when she heard the news.

A federal appeals court ruled Thursday to reject the Justice Department's decision and let the Texas statue remain in effect amid

the ongoing legal challenge. But, following that decision, the Department of Justice announced it plans to ask the U.S. Supreme Court for a ruling to temporarily block the restrictive abortion law.

As the decision likely moves toward the U.S. Supreme Court, the Texas law has become a rallying cry for anti-abortion rights advocates.

Anti-abortion activist Lila Rose is the president of Live Action. ABC

Anti-abortion activist Heather Gardner is the executive director of the Central Texas Coalition for Life. Gardner said she has spent a decade training "sidewalk advocates" to pray outside abortion facilities across the country.

Gardner said she acknowledges that some Texans will find ways around the law.

"We're very well aware that women will go to other states to have abortions," said Gardner. "We want women to not have to feel so desperate they have to do that."

Yet Lila Rose, the president of Live Action, said that Senate Bill 8 is still a historic win for the anti-abortion movement.

Anti-abortion activist Heather Gardner is the executive director of the Central Texas Coalition for Life. ABC

"It is the most, most legal protection in effect right now across the country for human lives," said Rose. "I think that Texas law should be an inspiration to other states because they found an enforcement mechanism that allows the lifesaving law to remain in effect."

Rose added she hopes the Texas law reframes the narrative around abortion.

"Our societal approach to pregnancy and motherhood and seeing that pre-born child as a threat or a risk or an enemy as opposed to a precious member of the human family," said Rose. "This is exactly what we should be focusing on, as opposed to promoting the death and destruction of children in the womb."

While the country remains focused on Texas, Brewer said she will continue to fight to keep the doors of her clinic open in Mississippi.

"I just feel good that they're able to come here. It's like, as tired as we are sometimes ... every day that I get to wake up and [help women], I'm OK," said Brewer.

Madi, who asked to only be identified by her first name, received an abortion in Mississippi. ABC

While she recovers from her procedure, Madi said she's sharing her story because she recognizes many women won't have same emotional and financial support that she had through the process.

"There were so many unneeded obstacles that I managed to get over but many women won't," said Madi. "I feel like this entire process of everything has happened for a reason. Everything happens in life for a reason and it's my chance to speak on it."

Madi said her story is meant to empower other women in her situation to fight back.

"My biggest thing is making sure that other women know that they're not alone. If Texas is gonna make this difficult, make it difficult for Texas," she said. "Don't go silently and if they need inspiration, I hope I can be that for them."

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Opinion | Why I violated Texas's extreme abortion ban

Left: On Nov. 20, 1971, demonstrators demanding a woman's right to choose march to the U.S. Capitol for a rally seeking repeal of antiabortion laws. (AP) Right: On Sept. 11, 2021, abortion rights activists rally at the Texas State Capitol in Austin. (Jordan Vonderhaar/Getty Images) (AP, Getty Images)

At the time, abortion was effectively illegal in Texas — unless a psychiatrist certified a woman was suicidal. If the woman had money, we'd refer her to clinics in Colorado, California or New York. The rest were on their own. Some traveled across the border to Mexico.

At the hospital that year, I saw three teenagers die from illegal abortions. One I will never forget. When she came into the ER, her vaginal cavity was packed with rags. She died a few days later from massive organ failure, caused by a septic infection.

In medical school in Texas, we'd been taught that abortion was an integral part of women's health care. When the Supreme Court issued its ruling in *Roe v. Wade* in 1973, recognizing abortion as a constitutional right, it enabled me to do the job I was trained to do.

For the next 45 years — not including the two years I was away in the Air Force — I was a practicing OB/GYN in Texas, conducting Pap smears, pelvic exams and pregnancy check-ups; delivering more than 10,000 babies; and providing abortion care at clinics I opened in Houston and San Antonio, and another in Oklahoma.

Then, this month, everything changed. A new Texas law, known as S.B. 8, virtually banned any abortion beyond about the sixth week of pregnancy. It shut down about 80 percent of the abortion services we provide. Anyone who suspects I have violated the new law can sue me for at least $10,000. They could also sue anybody who helps a person obtain an abortion past the new limit, including, apparently, the driver who brings a patient to my clinic.

For me, it is 1972 all over again.

And that is why, on the morning of Sept. 6, I provided an abortion to a woman who, though still in her first trimester, was beyond the state's new limit. I acted because I had a duty of care to this patient, as I do for all patients, and because she has a fundamental right to receive this care.

I fully understood that there could be legal consequences — but I wanted to make sure that Texas didn't get away with its bid to prevent this blatantly unconstitutional law from being tested.

Texas imposed a ban on abortions that kicks in as early as six weeks of pregnancy. Here's why that timeline is really much shorter for those who are pregnant. (Video: The Washington Post)

Though we never ask why someone has come to our clinic, they often tell us. They're finishing school or they already have three children, they're in an abusive relationship, or it's just not time. A majority are

mothers. Most are between 18 and 30. Many are struggling financially — more than half qualify for some form of financial aid from us.

Several times a month, a woman confides that she is having the abortion because she has been raped. Sometimes, she reports it to the police; more often, she doesn't.

Texas's new law makes no exceptions for rape or incest.

Even before S.B. 8, Texas had some of the most restrictive abortion laws in the country. That includes a 24-hour waiting period, meaning a woman has to make at least two visits to our clinic. Ultrasound imaging is mandatory. Parental consent is required for minors, unless they obtain court approval.

And yet, despite the restrictions, we were always able to continue providing compassionate care up to the legal limit of 22 weeks. It meant hiring more staff, everything took longer, but we managed.

Until Sept. 1.

Since then, most of our patients have been too far along in their pregnancies to qualify for abortion care. I tell them that we can offer services only if we cannot see the presence of cardiac activity on an ultrasound, which usually occurs at about six weeks, before most people know they are pregnant. The tension is unbearable as they lie there, waiting to hear their fate.

If we detect cardiac activity, we have to refer them out of state. One of the women I talked with since the law took effect is 42. She has four kids, three under 12. I advised her that she could go to Oklahoma. That's a nine-hour drive one way. I explained we could help with the funding. She told me she couldn't go even if we flew her in a private jet. "Who's going to take care of my kids?" she asked me. "What about my job? I can't miss work."

I understand that by providing an abortion beyond the new legal limit, I am taking a personal risk, but it's something I believe in strongly. Represented by the Center for Reproductive Rights, my clinics are among the plaintiffs in an ongoing federal lawsuit to stop S.B. 8.

I have daughters, granddaughters and nieces. I believe abortion is an essential part of health care. I have spent the past 50 years treating and helping patients. I can't just sit back and watch us return to 1972.

Chair NADLER. Without objection.

Ms. Bush.

Ms. BUSH. St. Louis and I thank you, Chair, for convening this hearing today. My plea today is with my colleagues on this Committee and with the American public watching.

Take a walk in the shoes of an 18-year-old girl from St. Louis, a Black girl, a girl who is uninsured and suffering from asthma, a health condition she likely got from the burning of fossil fuels in her community. She can't afford rent. She works a minimum wage job, and her friends consider her fortunate because at least she has a job.

Even in this job, she is making less than her White counterparts. She is also nine weeks pregnant, feeling alone and afraid. That girl is me. We don't live in a world that nurtures and cares for Black girls like me. If the world doesn't care about a Black girl like me, then what will happen to our Black babies who grow up to be Black—grow up to become Black children and Black adults.

Professor Bridges, you talk about the high mortality rates among Black pregnant people. In a world in which *Roe* is overturned, what harms do abortion bans pose for Black pregnant people?

Dr. BRIDGES. It would be coercing them to give birth, which is a dangerous proposition, which is something that should be embarrassing to the United States. The United States is one of the—it is actually the only industrialized nation that has an infant mortality rate that is increasing.

The racial disparities in maternal mortality mean that three to four times as many Black people should expect to die while attempting a birth. So, to coerce birth, which is what abortion bans and regulations do, is to coerce Black people to engage in a task that is dangerous to them.

Ms. BUSH. Thank you, Professor Bridges. May I ask you another question? Some scholars have compared this bounty system to the Fugitive Slave Acts, laws that offered a bounty for capturing and returning fugitive slaves and provided for fines up to $1,000 against anyone who helped a fugitive enslaved person. I agree.

Can you describe the White supremacist roots that link SB 8 and the Fugitive Slave Acts?

Dr. BRIDGES. Absolutely. So, the Fugitive Slave Act is an effort to ensure that people of color—Black people specifically—were human property, and that slavery as an institution would be perpetuated and that the people who purported to own those Black people would not lose their property.

So, essentially, the Fugitive Slave Act allowed others to control their bodies. Private actors, right, to control the bodies of other human beings. That is precisely what is happening in Texas today. In deputizing private citizens to seek a bounty on other private citizens, we are allowing private citizens to control, terrorize, regulate, the bodies of other human beings.

Ms. BUSH. Thank you. Thank you for explaining that Professor Bridges.

Dr. Moayedi, SB 8 has been law for 64 days, and in those 64 days clinics have closed and certain resources have been permanently erased. What are the permanent impacts of SB 8 on people of color and people living in poverty?

Dr. MOAYEDI. Thank you for that question. Representative Bush, thank you again for sharing your story. It moves me every single time, and it is the core of why I provide this care.

When I first started working in abortion care and realized the desperate need for women of color to take care of other women of color, that is what inspired me to become a physician and to provide abortion care in Texas. So, this issue is very dear to my heart.

This ban is disastrous for communities of color, especially the ones that I serve. Many of the people I take care of have never left the North Texas area, so traveling to Oklahoma City even is very challenging for them.

Last week, I took care of someone from the coast area in Texas that was coming to Oklahoma City. Because they had never left the State either, their friend made them a reservation in a hotel in Tulsa instead of Oklahoma City because they didn't really understand where to go. So, that is just one small story of how challenging and insurmountable getting out of the State for care can be.

What is truly frightening for me is what we are going to see in the next 7–8 months as far as maternal mortality in the communities that I serve. The people—yes.

Ms. BUSH. Thank you. Thank you for sharing that.

What I want to make clear here today, as the first Black woman and nurse to serve the people of Missouri in Congress, is that the path to overturning *Roe* will be devastating for all people, especially Black people. Abortion care would still exist, like it did before this landmark decision, but it will be deadly in a world where Black pregnant people die four times more often than White pregnant people during childbirth.

In a world where Black women are disproportionately evicted from their homes, in a world where Black trans-women are more likely to turn to sex for survival, failing to legislative reproductive justice is a death sentence for our neighbors, co-workers, and families.

We cannot afford to go back on our reproductive rights. We must legislate love. We must legislative justice for Black girls and nonbinary folks and guarantee reproductive rights for everyone.

Thank you, and I yield back.

Chair NADLER. The gentlelady yields back.

This concludes today's hearing. We thank the Witnesses for participating and for their patience for a very long day.

Without objection, all Members will have five legislative days to submit additional written questions for the Witnesses, or additional materials for the record.

Without objection, the hearing is adjourned.

[Whereupon, at 8:01 p.m., the Committee was adjourned.]

APPENDIX

ADVANCING BIRTH JUSTICE:

Community-Based Doula Models as a Standard of Care for Ending Racial Disparities

ANCIENT SONG DOULA SERVICES
VILLAGE BIRTH INTERNATIONAL
EVERY MOTHER COUNTS

Asteir Bey
Aimee Brill
Chanel Porchia-Albert
Melissa Gradilla
Nan Strauss

March 25, 2019

Ancient Song Doula Services is a social profit organization working towards addressing racial disparities and inequities within the healthcare system. We do this by providing full spectrum doula services, training & certification, conferences and educational forums to address the maternal mortality and severe maternal morbidity, implicit bias, and racism within healthcare systems.

VILLAGE
BIRTH
INTERNATIONAL

Village Birth International (VBI) is a community-based organization dedicated to improving outcomes in maternal-child health while seeking birth and reproductive justice for families facing inequities in the childbearing year. We are committed to universal health equity for all families by eliminating the impact of racism and systemic oppression on perinatal outcomes. Our work is currently based in Syracuse, NY, New Jersey, and Northern Uganda.

EVERY MOTHER COUNTS

Every Mother Counts is a non-profit organization working to make pregnancy and childbirth safe for every mother, everywhere. We work to achieve quality, respectful, and equitable maternity care for all by giving grants and working with partners and thought leaders to increase awareness and mobilize communities to take action.

Executive Summary

In 2018, New York State Governor Andrew Cuomo announced a comprehensive initiative to address poor maternal and infant health outcomes and disparities, which included the development of a Medicaid pilot program to cover doula services. This initiative includes the development of a Medicaid pilot program to cover labor support and home visits by doulas in order to address the discrimination and inequities in health care experienced by low-income communities and communities of color. Doula care includes non-clinical emotional, physical, and informational support before, during, and after labor and birth, and is covered by state Medicaid fee-for-service plans, managed care organizations, or both, in a few other states.

Extensive, reliable research shows that doula care is a high-value model that improves childbirth outcomes, increases care quality, and holds the potential to achieve cost savings.[1-3] Doula support during pregnancy, birth, and the postpartum period reduces rates of cesarean deliveries, prematurity and illness in newborns, and the likelihood of postpartum depression. Doula care also improves the overall satisfaction with the experience of childbirth care and increases breastfeeding initiation and duration.

Cost analyses have found that doula care can reduce overall spending by avoiding unnecessary medical procedures and the potential complications and chronic conditions that may result, reducing NICU admissions, and fostering healthy practices such as breastfeeding.[4-6] Despite the numerous, well-documented benefits of doula care, the services remain widely underutilized. A number of barriers contribute to poor access, but cost has previously been identified as the most significant obstacle to obtaining doula services. [10] Medicaid coverage would eliminate this barrier making doula support accessible to those who need it most.

"One of the most effective tools to improve labor and delivery is the continuous presence of support personnel, such as a doula."

– Safe Prevention of the Primary Cesarean Delivery. Consensus Statement of the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, March 2014.

New York State's commitment to the Medicaid Doula Pilot is a welcome step towards addressing long-standing health disparities, but to be effective, policies must incorporate and advance community-based doula approaches, including the responsibilities, core competencies, and principles of practice, which extend beyond those of the traditional doula model. Traditional "private-pay" doula care has been used primarily by people with private insurance, financial and social resources because it must be paid for out of pocket. The traditional doula model, and the trainings associated with it, do not address many of the issues that are essential to serving Medicaid enrolled clients with complex social needs.

Community-based doula programs have been developed to make doula care and other perinatal support services available in and appropriate for underserved communities. These programs and organizations are situated in the communities they serve, and their services encompass and go beyond those offered by private doulas. Community-based programs typically provide more home visits and a wider array of services and referrals for individuals who need more comprehensive support than would be provided by a traditional doula. The support provided is low or no cost and focuses on ensuring safe, dignified and respectful care. Most community-based doulas are members of the community they serve, sharing the same background, culture, and/or language with their clients and have additional training that supplements the traditional doula education curriculum.

Medicaid coverage makes doula support more accessible to communities with the greatest needs, and it has already been established in Oregon and Minnesota. An analysis of the utilization of Medicaid coverage in those two states shows that structural barriers have hampered widespread participation and suggests that Medicaid reimbursement is more likely to be successful when services are provided by doulas working in community-based organizations or programs. Such programs provide essential training, mentorship, supervision, and referral networks that enhance the impact and reach of their services.

This document will outline the ways in which community-based doula programs in New York State have been strategically implemented to serve families most at risk for poor maternal and infant health outcomes. By elevating human rights and reproductive justice principles, community-led doula support serves as a model for envisioning new approaches to the current maternal health crisis in the US. It will also outline successful elements of community-based doula trainings and practices that would enhance the New York State Pilot and help it meet its ultimate goal of reducing disparities.

Key recommendations:
New York and other states planning or providing Medicaid coverage of doula care should:

- **Adjust reimbursement rates** to ensure that doulas have the opportunity to earn a living wage
- **Collaborate with and invest in community-based doula programs** to ensure that doulas enrolled in Medicaid reimbursement programs are equipped to serve communities of color and low-income communities
- **Support best practices through the pilot design**, including ensuring adequate training, certification, supervision, mentorship and peer support to appropriately serve communities of color and low-income communities
- **Develop a comprehensive approach to wellness and support by ensuring organizations or agencies** are equipped with the structure, relationships, and processes in place to provide a coordinated network of referrals
- **Provide funds to train and certify a diverse doula workforce,** specifically from underserved rural and urban low-income communities, communities of color, and communities facing linguistic or cultural barriers.
- **Incorporate community engagement as an essential component to improve health equity.**
- **Take active steps to raise awareness about the benefits and availability of community-based doulas**.

Understanding the limitations of efforts underway opens the door to identifying strategies to make the NY State Pilot, and future programs in other states, as successful as possible.

WHAT IS DOULA CARE?

Doulas are trained to provide non-clinical emotional, physical and informational support for people before, during, and after labor and birth. Birth doulas provide hands-on comfort measures and share resources and information about labor and birth. Doulas can facilitate positive communication between the birthing person and their care providers by helping people articulate their questions, preferences and values.

In addition to providing continuous support during labor and childbirth, birth doulas typically meet with clients one or more times at the end of pregnancy, as well as early in the postpartum period, although some hospital-based doula programs provide care only during labor and birth. In the postpartum period, doulas may offer help with newborn feeding and other care, emotional and physical recovery from birth, coping skills, and appropriate referrals as necessary.

Doulas work with pregnant people to help them experience care that is individualized, safe, healthy, and equitable. **Doulas can be particularly beneficial for women of color and women from low-income and underserved communities and can help reduce health disparities by ensuring that pregnant people who face the greatest risks have the added support they need.**

Doula care can vary significantly depending on their training and approach. Community-based doulas offer an expanded model of traditional doula care that provides culturally appropriate support to people in communities at risk of poor outcomes. They are usually trusted members of the community they serve who are particularly well-suited to address issues related to discrimination and disparities by bridging language and cultural gaps and serving as a health navigator or liaison between the client and service providers.

Community-based doula programs include services tailored to the specific needs of the community they serve at no or very low cost. In addition to birthing support, community-based doulas usually offer prenatal and postpartum home visits, childbirth and breastfeeding education, and referrals for needed health or social services. Many also support attachment and responsive parenting.

Because the benefits are particularly important for those most at risk of poor outcomes, **doula support has the potential to reduce health disparities and improve health equity.** But for women in low-income communities living in maternal toxic zones, doula care is often out of reach due to financial constraints and the limited availability of doulas in their communities.

"Most of the time, mothers from my community are alone in the hospital. For my refugee community, to be a new mother in this country means being afraid and not knowing how to navigate this system. The language barrier makes it very difficult for them and they need someone they can trust to encourage them and reassure them. Having a doula from their own country makes them feel safe, comfortable, and helps the mother understand the process."

Juliet Ilunga, Certified Village Birth International Doula, Syracuse, NY March 13, 2019.

Introduction

MATERNAL HEALTH LANDSCAPE

In April 2018, New York State Governor Andrew Cuomo announced a comprehensive initiative to reduce maternal mortality and racial and economic disparities in maternal and infant health outcomes. By highlighting the high rates of maternal death and illness, specifically those of black women, this announcement opened new opportunities for partnership between state policy makers and the community members most affected by pregnancy- and childbirth-related disparities.

Despite decades of medical advancements, maternal and infant death, illness and injury persist at alarming rates, particularly in communities of color and low-income communities. In New York State, maternal deaths and severe complications of pregnancy remain higher than the national average and have been increasing. NY State maternal deaths increased by 60% over the last decade, reaching 20.9 deaths per 100,000 live births in 2015.[12] In New York City, where half of all births in the state take place, the maternal mortality rate is even higher (22.6 deaths per 100,000 live births).[13] Life-threatening complications of pregnancy and birth (severe maternal morbidity) are 1.6 times higher than the US average and increased 28.2% from 2008 to 2012 (197.2 to 252.9 per 10,000 live births). [14]

As is true for the US overall, New York State maternal mortality rates for black women are between three and four times higher than those of white women.[13, 15]. According to the 2017 New York Maternal Mortality Review report, 68% of women that experienced a pregnancy-related death were enrolled in Medicaid.[16] Similarly, rates of maternal mortality and morbidity in New York City are highest among women of color and women living in high poverty communities. From 2006 to 2010, black women were twelve times as likely to die from pregnancy-related causes compared to white women (56.3 per 100,000 live births compared to 4.7).[13] The rates were also high among Hispanic and Latina women and Asian/Pacific Islander women (15.9 and 19.9 per 100,000 live births, respectively).

Maternal health outcomes are equally dire in other regions of New York State. In Onondoga county, where Village Birth International is based, maternal and infant mortality rates are higher than state averages. In this region, the maternal mortality rate is 31.6 deaths per 100,000 live births.[17] Infant mortality is 6.2 deaths per 1,000 live births with significant racial disparities (14.8 for black infants and 4.4 for white infants).

STRATEGIES FOR CHANGE

Programmatic strategies specifically targeting maternal and infant health outcomes are an essential addition to efforts to improve clinical care and include providing community-based doula support for at-risk women and families. Strategies to improve infant and maternal outcomes, particularly for families of color and low-income families, have historically focused disproportionately on addressing pre-existing conditions, structural barriers to care access, and individual behavior. A successful approach to improving outcomes for families requires incorporating human rights and reproductive justice frameworks that not only value lived experiences, but that also center community-led approaches to resolving the maternal health crisis in the US.

In order to tackle racial disparities in maternal and infant health, state agencies must examine health care systems with a race equity lens. Solutions to racial disparities in birth outcomes must be designed with a full understanding of the racial barriers, socially constructed yet systematically upheld, which exclude families from accessing equitable options for healthy living including reproductive choice.

Resources articulating the needs of communities facing the highest risk for poor maternal outcomes, as well as proposed solutions, have already been developed. In 2016, the Center for Reproductive Rights and SisterSong Women of Color Reproductive Collective published "Black Mamas Matter: Advancing the Human Right to Safe and Respectful Maternal Health Care." Using a human rights framework to develop maternal health solutions grounded in reproductive justice, the toolkit highlights poor outcomes as preventable yet resulting from "laws, policies, and institutional practices that can be changed."[18]

Honoring the commitment to a human rights approach in respectful maternity care also ensures government accountability in the core obligations of respect, protection and fulfillment of optimal health care for all people. Additionally, policies must reflect the essential elements of the right to health: availability, accessibility including non-discrimination and economic accessibility, acceptability including culturally respectful care, and quality.[19]

New York State's commitment to the Medicaid Doula Pilot is an important step towards addressing long-standing health disparities. However, to be effective, policies must incorporate input and feedback from community-based leadership and advance their recommendations for family-centered models of care. **Program activities and training must extend beyond traditional doula models of care and incorporate aspects of community-based programs if they are to achieve the Pilot's stated goals of reducing disparities and improving health outcomes.**

Reimbursement rates must be sufficient for doulas to earn a livable wage. Community-based programs must have the capacity to support workforce development and subsidize doula training for a diverse group of doulas to work in a variety of communities. Collaborative relationships need to be established to connect Medicaid and other payers with health professional associations and health care delivery systems to increase uptake of doula services.

Medicaid coverage of doula support is increasingly recognized as a promising model to improve maternal and infant health outcomes, improve the experience of and satisfaction with care, and improve health equity, while reducing or maintaining current levels of health

BENEFITS OF DOULA CARE

Doulas are well-positioned to improve outcomes in communities of color and low-income communities. Doula support has been well-documented to improve health outcomes, enhance care engagement and satisfaction, and reduce spending on unnecessary procedures and avoidable complications.

The benefits of doula care are supported by consistent, high-quality research.[1] Cochrane systematic reviews have reported the positive effects of continuous labor support since 1995.[7] In 2017, the most recent review analyzed data from 26 individual studies involving more than 15,000 women.

The review found numerous benefits to continuous labor support and no known harms of such care, including:

- **39% reduction in the likelihood of cesarean births**
- **15% greater likelihood of a spontaneous vaginal birth**
- **10% reduction in the use of pain medications**
- **Shorter labor by an average of 41 minutes**
- **31% reduction in reporting a negative birth experience**

Other studies have found that community-based doula support that begins during pregnancy and continues through childbirth and the postpartum period is associated with lower rates of preterm and low birthweight births and postpartum depression, while increasing breastfeeding initiation and duration. [2, 3, 8, 9]

In the Safe Prevention of the Primary Cesarean Delivery, the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM), the pre-eminent professional associations for obstetric care, report that **continuous labor support by a doula is "one of the most effective tools to improve labor and delivery outcomes."**[11]

spending. As New York and other states prepare to design and implement Medicaid doula reimbursement programs, approaches must move towards successful implementation by collaborating with and engaging community-based partners. Communities and state agencies must work to build sustainable programs that are equitable for doulas and that have the potential for long-lasting health improvements for women and infants.

Community-Based Doula Models Are Uniquely Suited to Address Disparities

Community-supported birth has always been a fundamental characteristic of healthy pregnancy, childbirth, and parenting outcomes for all people across circumstance, time, or geographic location. Much of the literature on maternal health and reproductive disparities highlights social determinants of health as the drivers of inequity. While poverty and inadequate resources certainly affect quality of life, levels of chronic stress, and health, a singular focus excludes the burden of racism, gender oppression, obstetric violence, and institutional policies that negatively affect pregnant people of color.

Birth workers of color are responding to the maternal health crisis with doula care that is reflective of the needs of families in their local communities. Communal responses to disparities reveal the activation of pregnant people raising their families in environments where resources, dignity, quality care, support and humane treatment are scarce. Solutions for mortality and morbidity in birth actually reside in the resilience of people facing inequity every day.

Racism and implicit bias continue to drive health inequity in the United States. Community-based doula care reflects an organized, collective framework where African American, African immigrant/refugee, Latinx, Indigenous or historically underserved individuals formalize and implement programs with the specific aim of serving their own communities. Fundamental values of support are rooted in individual wisdom and self-determination. These programs are culturally infused, generationally informed, and responsive to years of ongoing oppression resulting in trauma informed actions that pull families together in crisis.

The collective action of community-based doula care supports a pregnant person and their family in the childbearing year. The intimacy and cultural humility provided through that care serve to mitigate effects of inequity and disparities in health care. Health care systems that serve communities of color through a one-dimensional approach in birth continue to contribute to preventable death, complications, and illness. Community-led doula models reframe the current health care model by advancing policy and engagement that reflects improving the quality of medical care, cultural humility, and implicit bias awareness for providers and caregivers.

Situated in the communities they serve, community-based doula programs generally encompass all of the services that private doulas offer, and add additional home visits and a wider array of services and referrals for individuals who need more comprehensive support. Most community-based doulas are members of the community they serve, sharing the same background, culture, and/or language with their clients. Community-based doulas have additional training that supplements the traditional doula education curriculum. Care provided is low or no cost and is grounded in safe, dignified and respectful access to health care.

"We're talking about systemic oppression and if we can't recognize it for our own people then we're not going to know how to annihilate it. Everything is relevant."

- Dawn Wright-El, V8I Community Doula

Organizations like Ancient Song Doula Services, Village Birth International, Black Mamas Matter Alliance, Black Women Birthing Justice, Mamatoto Village, Commonsense Childbirth, Mama Sana Vibrant Woman, Uzazi Village, Tewa Women United, ROOTT (Restoring Our Own Through Transformation), and others work to bridge disparities in maternal/infant health by offering and engaging community members in education, advocacy, policy work and full-spectrum community-based doula care services, as well as by training members of the communities within their immediate areas and across the US.

Research related to community-based doula programs has demonstrated the benefits of this approach.[2, 20] In 2012, an expert panel on the "Promotion and Support of Community-based Doula Programs" convened to evaluate, discuss, and identify key lessons from four years of Health Resources and Services Administration (HRSA) funding of community-based doula programs. This panel found significantly higher breastfeeding rates and lower cesarean rates among participants in community-based doula programs. Specifically, 87% of community-based doula clients were breastfeeding at six weeks compared with 61% of the comparison group; at 3 months, 72% were still breastfeeding compared with 48% of the comparison group.[2] This panel emphasized that "HRSA should continue to promote and expand Community-based Doula Programs with federal funding, based on the uniqueness of the model, the workforce development implications, and the data analysis which identifies significant and important outcomes."

COMMUNITY-BASED MODELS OF PRACTICE AND TRAINING ARE ESSENTIAL

In order to achieve long-standing positive outcomes in maternal health care, it is essential that community-based models of doula care are highlighted and replicated. Community members have the expertise to articulate programmatic models of care and reimbursement rates that will lead to improvements in quality of life and better individual birth outcomes, and as such are essential participants in efforts to shape state policy and institutional practice.

To meet the needs of clients facing complex social, economic and environmental issues, such as homelessness, mental illness, and intimate partner violence, community-based doulas are prepared to and skilled at providing culturally competent, trauma informed, social, emotional, and informational support to their clients. Community-based programs, trainings, mentorship, supervision, and peer support include core competencies nationally recognized for doula certification, as well as additional components that address the need to incorporate a human rights, birth justice, anti-racist, and culturally relevant framework that clearly defines and addresses disparities and strategies to engage with families experiencing institutional racism and discrimination in health care. Training, mentorship, supervision, and peer support includes navigating the social determinants of health affecting birth disparities, a full understanding of local resources and referral options, and applying a reproductive justice framework.

Traditional doula organizations historically have not centered the leadership, voices, or experiences of people of color or low-income communities. These are key tenets of community-based doula organizations. Traditional doula trainings provide a doula with the skills to provide unconditional, non-judgmental support, but lack a historical, educational cultural context on how race, institutional and interpersonal bias, and other social determinants play an integral role in birth disparities affecting communities of color. Under traditional models, doulas are trained in an entrepreneurial private practice framework that differs in purpose and mission from community-based doula work.

Community-based doula programs add multiple prenatal and postpartum home visits, referrals to comprehensive support, and additional resources, to the services typically provided by a traditional doula.

Standard or traditional doula trainings typically prepare doulas to work as independent entrepreneurs immediately following their training. They do not include ongoing supervision or mentorship, as is common in community-based programs. A typical doula training consists of 16 hours of group classroom time, after which new doulas have one to two years to independently complete any program requirements for certification. Trainers can be from locations other than where they are conducting the training, which usually do not include information specific to any particular area or community.

COMMUNITY-BASED DOULA PROGRAMS IN NEW YORK

Ancient Song Doula Services and Village Birth International have been providing community-based doula support in New York State for ten and eight years, respectively. These organizations were formed by women of African descent who directly experienced the hardships of the maternity care system in the US. The founders' lived experiences were the catalysts that prompted them to organize and frame practices that would improve the lives of others in their communities. The human rights and reproductive justice frameworks, as defined below, are fundamental to all services provided. As kindred partners and collaborators in the Black Mamas Matter Alliance, Ancient Song and Village Birth International not only work to ensure respectful maternity care and center solutions for the black maternal health crisis, but also develop policies that have a positive impact on the families they see every day. The following sections describe the principles, strategies, and priorities of their work.

Principles of Practice for Community-Based Doula Care

The principles of practice embedded in community-based doula programs differ from the model of care practiced by traditional doulas. Community-based doula programs best meet

the needs of communities of color, low-income communities, and other communities facing barriers and disproportionately poor health outcomes, when they:

Community-based doulas lead with the understanding that choice, access and informed, shared decision-making in pregnancy, childbirth, and reproductive care are central to improving outcomes. Listening to and valuing the autonomy of pregnant people guide supportive responses.

- **Incorporate a human rights framework** to address physical, emotional, psychological, and social elements of health in order to create the best outcomes for pregnant people and babies. The fundamental right to health is centered and focuses on making sure services are available, accessible, acceptable and of excellent quality.
- **Are rooted in an understanding of racism and** discrimination, including the historical trauma of racism and implicit bias and their impact on maternal health disparities and the reproductive health of pregnant and parenting individuals.
- **Center a culture of care recognizing the intersections of health and racial equity**, the interrelation of health and equity, and the relationship of health equity to a pregnant person's access to care and their choices of care providers.
- **Address intergenerational trauma of people of color** and centered communities to incorporate their lived experiences and recognize the direct impact of trauma and stress on infant and maternal health.
- **Are community-based,** meaning that participants either are trusted members of the communities they serve, come to birth work with a broad range of complex experiences that mirror the communities they serve, or have a deep understanding of these communities.
- **Expand the traditional doula framework** beyond the perinatal, birth, and postpartum periods to a model that connects maternal health advocacy and direct engagement with the communities in which we live in the US.
- **Provide a platform for solution driven responses** to long-standing infant and maternal mortality and morbidity.
- **Adopt a life-course perspective**, recognizing that respectful maternity care includes reframing the experience of childbirth not as a single medical event, but as a series of experiences over a person's lifespan that transition the individual into parenthood.
- **Support the development of a Reproductive Life Plan** that provides non-directive, non-coercive, and fully informed options that are family driven and culturally relevant.
- **Prioritize the self-determination, compassion, and trust in the individual wisdom of families served.** Community-based doulas lead with the understanding that choice, access and informed, shared decision-making in pregnancy, childbirth, and reproductive care are central to improving outcomes. Listening to and valuing the autonomy of pregnant people guide supportive responses.
- **Value collective models of care** that enable doulas to support groups of pregnant people together as they build lasting relationships during the transition to parenthood. Prenatal and postpartum care offered in communal spaces to support mental health, education, and promote healing between pregnant families facing disparities or adversities in reproductive care. These communal healing spaces are used to mitigate the effects of toxic environments and increase community-based problem solving.

Professional Standards of Community-Based Doula Care

Professional standards establish that community-based doulas are expected to:

- **Inform clients about their human right to respectful care and shared decision-making,** including informed consent, refusal without reprisal, and choosing treatment alternatives free from fear-based coercion.
- **Evaluate evidence-based research findings and current best practices**, understand the strengths and limitations of such studies, and trust the pregnant person to make the best decision as the expert regarding their own care.
- **Understand the complex identity of the pregnant person** they are supporting.
- **Learn to use advocacy tools and methods of communication to ensure that the pregnant person is centered in a position of agency** in relation to the hospital staff and other care providers attending the birth. These strategies encourage the provider to listen more than speak, to be aware of their power, and to provide care that allows for clients to exercise agency and empower themselves.
- **Provide non-clinical care including physical comfort measures, emotional support, informational assistance, and client advocacy** during childbirth, the postpartum period, and abortion (in full-spectrum programs).
- **Abide by Standards of Practice and Code of Ethics as set by the certifying agency.**

Core Competencies

The following core competencies reflect the skills, knowledge, and attributes needed by a community-based doula to carry out their responsibilities, grouped to indicate which are shared by doulas in community-based and traditional roles and which are unique to the community-based model.

All doulas should develop and maintain their skills in the following areas:

Shared by Both Traditional and Community-Based Doulas

- Understanding of anatomy and physiology as related to the childbearing process;
- Capacity to employ different strategies for providing emotional support and resources;
- Skills providing a wide variety of labor coping strategies;
- Strategies to foster effective communication between clients and clinicians by employing a range of positive communication techniques;
- Awareness of allopathic and holistic health care systems and various modalities of care that doulas can refer clients to in order to address client needs beyond the scope of the doula (e.g. acupuncture)
- Knowledge of strategies for supporting breastfeeding/chestfeeding, breast-milk feeding, and lactation.

Community-based doulas are prepared to and skilled at providing culturally competent, trauma informed, social, emotional, and informational support to their clients.

Unique to Community-Based Doulas

- Understanding of ways that social determinants affect pregnancy, childbirth, and the postpartum period and the local resources available to support families, including transportation assistance, financial support, mental health resources, substance abuse counseling, incarceration advocacy, access to health services and insurance, housing assistance, environmental justice-toxic lead conditions, immigration assistance, and others
- Understanding process and importance of making referrals to appropriate social support services and follow-up (including WIC, housing, case management) and

community-based health care systems that promote the advancement of the pregnant person and community

- Skills providing lactation support including sharing knowledge of the significance and impact of breastfeeding for families facing health disparities, including a thorough understanding of structural, physical and emotional barriers to breastfeeding in communities of color, low-income communities, and the communities doulas plan to serve
- Understanding of reproductive justice and birth justice frameworks and how they intersect
- Cultural sensitivity to the lived experiences of people of color, Indigenous people, people in low-income communities, and an understanding of the impact of structural racism and implicit bias role in accessing care, experiences of care, and birth outcomes
- Modalities of practice that are culturally sensitive and relevant to the pregnant person's needs based on an understanding of experiences that may reflect societal, institutional, or interpersonal bias
- Cultural humility and recognition of the intersectional needs of the childbearing person across the reproductive health spectrum
- Various strategies to address structural and institutionalized racism and intergenerational trauma (i.e. trauma informed care)
- Understanding of the value of community representation in the doula workforce, recognizing the benefit of families being served by individuals who share ethnic, racial, and cultural backgrounds as well as lived experiences in transitioning to parenthood
- Incorporate doula skills to support individuals throughout their reproductive life course.

"Community doulas being there is a way to help a sister make these disparities better. Reminding people that they're not a burden is very important."

Tanaya Thomas Edwards, VBI Community Doula

Elements of Community-Based Doula Practice

Doulas should be prepared to offer the following to their clients as appropriate:

Shared by Both Traditional and Community-Based Doulas

- Information and support on general health practices that enhance normal functioning pertaining to pregnancy, childbirth, postpartum, and the newborn
- Evidence-based information on the uses, benefits, and risks of medical interventions, pain medications, and Cesarean birth
- Unconditional, continuous support, and care for the laboring pregnant person and their support people/person with attunement to their physical, emotional, and psychological needs
- Emotional support, physical comfort measures, and physiological pain management techniques to assist coping with labor and birth and guidance to help navigate decisions and avoid unnecessary medical interventions
- Guidance to help navigate decisions and avoid unwanted and unnecessary medical interventions
    - Explanation of medical procedures, interventions, inductions, or Cesarean
    - Initial breastfeeding and newborn care support
    - Ongoing support for partner or anyone else present at the birth
- Evidence-based information on infant feeding, general breastfeeding guidance and referral to lactation resources as needed

- Make appropriate referrals in allopathic and holistic health care systems to address client needs beyond the scope of the doula
- A collaborative approach to working with pregnant people and their chosen care providers and support community
- Encouragement of bodily autonomy, advocacy, and informed consent for the pregnant person and newborn
- Education on infant soothing techniques and coping skills for new parents.

Unique to Community-Based Doulas

- Evidence-based pre-conception, inter-conception and post-partum education and resources that can improve childbirth-related outcomes
- Collaboration with other health care and social service providers when necessary (including transportation, housing, alcohol, tobacco, and other drug (ATOD) cessation, WIC, SNAP, and intimate partner violence resources)
- Referrals and assistance obtaining appropriate social support services and follow up (including WIC, housing, case management) and community-based health care systems that promote the advancement of the pregnant person and community.
- Assistance in preparing for and carrying out a pregnant person's plans for their childbirth that affirms their race, gender, sexuality, and cultural and religious beliefs, practices, and traditions
- Support achieving Respectful Maternity Care for the family and aligning values of care as articulated in the Black Mamas Matter Alliance toolkit, including that all women have the right to respectful maternity care that supports healthy pregnancies and birth
- Trauma informed care practices
- Community education and engagement. Community-based doulas as reproductive and maternal health educators to mobilize and inform families on choices for improving health outcomes in the childbearing year
- Continuity of Care: Providing support and resources to the family from birth through the baby's first year

Medicaid Pilot Models

NEW YORK PILOT MODEL

The NY State Department of Health has made the details of the New York State Medicaid Doula Pilot Program available on their website and has shared it with community organizations. Implementation was set to begin on March 1, 2019 in Erie County (Buffalo), with implementation in Onondaga (Syracuse) and Kings (Brooklyn) Counties on hold until sufficient numbers of doulas have registered to participate. The pilot will be available for anyone enrolled in Medicaid in fee-for-service or managed care plans who reside in those counties, which were selected for their high maternal and infant mortality rates and high number of births covered by Medicaid.

All participating doulas must apply for enrollment with the state and are required to provide a doula training certificate or proof of doula training and must also meet the following requirements for training:

- At least 24 contact hours of in-person education that includes any combination of childbirth education, birth doula training, antepartum doula trainings, and postpartum doula training
- Attendance at a minimum of one (1) breastfeeding class
- Attendance at a minimum of two (2) childbirth classes
- Attendance at a minimum of two (2) births
- Submission of one (1) position paper/essay surrounding the role of doulas in the birthing process
- Completion of cultural competency training
- Completion of a doula proficiency exam
- Completion of HIPAA/client confidentiality training

The scope of services for the project allows up to 4 prenatal visits ($30/visit), intrapartum care ($360), and up to 4 postpartum visits ($30/visit) for a total of $600 for all services. Fees were calculated at approximately 43% of NY OB/GYN professional fees and 50% of midwifery services fees. Doulas must bill for each visit and at this time must do so as individual providers, rather than through an organization billing on behalf of the doulas who work with them.

MEDICAID COVERAGE IN OTHER STATES

Statewide, Oregon Medicaid reimbursed a total of:

- **41 claims in 2016**
- **27 claims in 2017**
- **24 claims between January and June 2018.**

The New York Pilot has been based in large part on similar efforts in Oregon and Minnesota. While these two states, the only ones with statewide coverage, deserve recognition for being early adopters of Medicaid doula coverage, implementation has proven difficult. A careful look at the history of these programs indicates that the states' laudable efforts to innovate should serve as a starting point for further refinement.

In these states, doulas can bill independently or have a physician or midwife bill on their behalf and then collect the fee from that health care provider. In Minnesota, doula agencies or organizations can also bill on their behalf for doula services. An examination of the design of these programs provides valuable insight into the challenges of implementation and offers lessons learned to move forward in developing a new model, such as the New York Pilot.

Oregon

In 2013, Oregon became the first state to include birth doula services in Medicaid coverage, based largely on their potential to reduce health disparities. Under Oregon's program, trained birth doulas can register to become "Traditional Health Workers (THW)," a parallel profession to Community Health Workers.[1] THW doulas are eligible to bill for two prenatal visits and two postpartum visits ($50/visit) and intrapartum care ($150) for a total fee of $350 under fee-for-service Medicaid. Some doulas have been able to negotiate higher rates with individual Medicaid coordinated care organizations.[21]

[1] The other four categories of THWs are community health workers, personal health navigators, peer wellness specialists, and peer support specialists.

Structural barriers in the state's THW doula certification and reimbursement systems have resulted in low participation rates by doulas, and the program has been unable to achieve its goals. **As of 2018, utilization was still extremely low, with just 121 claims for doula services having been submitted and 92 reimbursed between January 2016 and June 2018:**

- 41 claims reimbursed in calendar year 2016
- 27 claims reimbursed in calendar year 2017
- 24 claims reimbursed between January 2018 and June 2018
- 24% of claims submitted were denied (29 of 121 claims). [22]

THW birth doulas have reported that low reimbursement rates and significant barriers in the billing process have deterred widespread utilization. Additional barriers include a lack of support for doulas by the medical community, a lack of funds for doula trainings, limited doula services in rural areas, challenges accessing state certification requirements, and difficulties navigating the state doula/THW certification process. [22]

In order to address these barriers and the low utilization of Medicaid reimbursement for birth doula services, the non-profit organization Heart of the Valley Birth and Beyond obtained grant funding to create the Community Doula Program (CDP) in Corvallis, Oregon. The CDP has trained three cohorts of doulas (a total of 88 doulas trained) - the majority of whom represent and have the capacity to serve Oregon Health Authority's priority populations. Program staff also are responsible for coordinating referrals, socially and culturally-matching doulas with clients, as well as managing billing and reimbursement. The CDP also provides peer-to-peer mentorship, support, professional development and continuing education opportunities for CDP doulas. In addition to increasing the accessibility and availability of doula trainings and births, the CDP is collecting health outcomes data and conducting a qualitative assessment on the experience of CDP doula care from the perspective of clients, doulas, collaborating providers and referrers.[21]

In 2018, the Minnesota legislature voted to increase Medicaid reimbursement rates for doula care to $47 for each home visit and $488 for each birth, 57% and 36% higher than in New York State.

Minnesota

In 2014, Minnesota also launched a Medicaid doula reimbursement program in fee-for-service and managed care plans. Like Oregon, Minnesota's program was intended to respond to racial and geographic disparities in maternal and infant health outcomes, and like Oregon, it has experienced substantial barriers to implementation. In **Minnesota**, certified doulas who become registered with the state are eligible to bill up to a total of $411, for attending the birth plus 6 visits either prenatally or postpartum.[23] Challenges in Minnesota have included low reimbursement rates, doulas experiencing difficulties enrolling as providers with managed care organizations, and the need to bill under the NPI of an independent (not MCO-employed) licensed midwife or physician. Representation of communities of color among trainers and doulas is limited by the low fees and also by the costs of certification and registration.

In 2018, the Minnesota legislature introduced a new bill to increase Medicaid reimbursement rates for doula services, to increase utilization of doula services. Prenatal and postpartum visits would be raised to $47 and labor and birth support to $488, for a total reimbursement of $770. The bill passed both the Minnesota House and Senate, but ultimately was not signed by the governor, because it had been inserted into a large omnibus budget bill that included unrelated and highly contentious provisions.[24] The same bill (HF 259 / SF 1044) has been reintroduced in the 91st Legislature (2019-2020) and is expected to pass and go into effect later in 2019.

LESSONS LEARNED FROM EARLY IMPLEMENTATION EFFORTS

Including community-based organizations as partners in the work of program development and implementation would help avoid the problems encountered in Oregon and Minnesota. In particular, community organizations have the knowledge, expertise, and relationships needed to identify feasible reimbursement rates, to appropriately lead and mentor a diverse community of doulas through training, certification and service provision, and to support the process of applying to become a state-recognized service provider.

In both states, the extremely limited implementation has deterred additional doulas from registering with Medicaid until they see evidence of the program's effective operation. Community-doula organizations, academics, and advocacy groups have made a number of financing and policy recommendations to improve the implementation of these programs and to ensure that future programs take lessons learned into account. These recommendations emphasize the need to:

- Increase doula reimbursement rates
- Utilize grant programs or other outside funding sources to support workforce development and subsidize doula training
- Increase diversity of doulas and their availability in underserved urban and rural communities
- Develop collaborative relationships connecting various stakeholder groups including Medicaid, other payers, health professional associations, and health care delivery systems, to increase uptake of doula services.

Reimbursement Rates

For a Medicaid doula pilot to operate and become sustainable, reimbursement rates must allow community-based doulas to support themselves and their families at a living wage. Currently, New York State rates are set at $30 for each prenatal and postpartum visit (up to 4 of each), and $360 for attendance at the birth, for a maximum total of $600.

Doulas already serving low-income communities and communities of color in Kings County have reported to their programs' supervisors that the low rates are a deterrent to their participation in the Medicaid pilot. Shortly before the March 1, 2019 pilot launch, few doulas from Kings County had registered with the state, leading the state to delay implementation in Kings County. Because low reimbursement rates have also been a leading reason cited for low participation in Medicaid coverage in other states, this section will detail why compensation rates must be increased and will identify alternatives that are better aligned with the types of services community-based doulas provide and the time spent with clients.

The method that NY Medicaid has employed to determine rates - setting doula reimbursement levels at a percentage of physician and midwife rates - is inherently problematic. Physicians and midwives are compensated for their time at substantially higher rates than doulas, which is appropriate given the differences in training, roles, and

level of responsibility.[ii] However, the amount of time doulas spend with clients and performing unbillable responsibilities, as well as their expenses and unpredictable work hours must be taken into consideration when setting reimbursement amounts, if Medicaid doula coverage is to succeed.

Several additional rationales support significantly increasing current rates:

- At planned rates, doula compensation would fall below the equivalent of the minimum wage for New York City.
- Planned Medicaid rates are significantly lower than those of all three doula programs currently serving communities of color in Kings County (Ancient Song Doula Services, By My Side Birth Support Program, and Healthy Women Healthy Futures).
- Recent pilots and proposed legislation are setting rates higher than those planned by New York State.
- Proposed rates are significantly lower than the rate at which doula support would "break even," according to recent studies that each considers just a subset of the expected health care cost savings.[3-5]

Provider Medicaid reimbursement levels vary significantly by state and Medicaid is currently compensating midwives and physicians at rates so low making childbirth related care a "loss-leader," particularly for uncomplicated vaginal births.[25] Rather than extending that philosophy to create a new group of undercompensated health professionals, payment rates must be re-calibrated to achieve the best health outcomes possible for the resources expended and fair compensation for the workforce.

PHYSICIAN AND MIDWIFE PAYMENTS ARE NOT APPROPRIATE BENCHMARKS FOR DOULA RATES

Fair and reasonable reimbursement rates cannot be calculated using physician and midwife fees as a benchmark or comparator, because this approach overlooks fundamental differences between the workflow, costs incurred, and employee status of the two groups.

- Community-based doulas spend considerably more time with a person than health care providers in clinic and hospital settings.
- Doulas are independent contractors who do not receive employee benefits and incur out of pocket expenses.
- Doula work includes considerable uncompensated time that should be reflected in rates.

Doulas spend 6 to 11 times as much time with clients as do health care providers working in a hospital or clinic setting.

[ii] The rates paid by NY Medicaid to health care providers for uncomplicated vaginal births are currently under-reimbursed and are too low to be sustainable unless they are balanced out by other types of fees (e.g. private insurance or out of pocket payments for vaginal birth, or other revenue sources such as cesarean births and other surgical procedures). This is relevant because community-based doulas are unlikely to have other sources of income, making low Medicaid rates particularly onerous.

Typically, routine prenatal and postpartum visits with a health care provider last about 15 minutes [26] or less, whereas a community doula spends on average two hours with a client at prenatal and postpartum visits, usually meeting at the client's home, with the attendant round trip travel time.

If a pregnant person is already enrolled in Medicaid, can access prenatal care without delay, and receives the recommended 14 visits[27] plus one postpartum visit at 15 minutes each, that would total approximately 225 minutes, or 3.75 hours, of time spent in prenatal and postpartum office visits.[iii] By contrast, a community-based doula attends 8 prenatal and postpartum visits that each last approximately 2-hours for a total of 16 hours. Additionally, doulas are available for responding to texts, emails, and calls throughout the weeks or months they are supporting their client and spend significant time traveling to and from each visit at the client's home.

Community-based doulas spend an average of 6 to 11 times as much time per client than health care providers.

The discrepancy in time holds true for labor and childbirth. During labor, the health care provider checks in periodically and attends the last stages of birth, usually only until the end of their shift. Health care providers in hospitals are generally responsible for several patients at once and usually spend less than two hours with a patient in labor and childbirth including both periodic checks and attendance at the actual birth.

By contrast, birth doula care is defined explicitly as "continuous" labor support throughout labor and childbirth, ranging from a few hours to a few days and averaging about 18 hours.[22, 28] Doula support begins in a client's home and continues until an hour or so following childbirth, reflecting a considerably longer time commitment than that of the health care provider. (See Table 1. for a detailed comparison of time spent with a patient or client by healthcare providers and community-based doulas).

TABLE 1: ESTIMATED TOTAL TIME SPENT PER PATIENT, BY SERVICE TYPE

	Health Care Services			Community-Based Doula Services		
Activity	Number of visits	Hours per visit	Total Hours	Number of visits	Hours per visit	Total Hours
Prenatal Visits	14	.25	3.5	4	2	8
Postpartum Visits	1	.25	.25	4	2	8
Labor/Birth	1	2	2	1	18	18
Remote client support - phone, text, email						2
TIME (excluding transportation)			5.75 hrs			36 hrs
Time transportation - home visits + birth	-	-		9	1	9
TOTAL TIME			5.75 hrs			45 hrs

[iii] This is a conservative estimate. Numerous barriers to entering care and attending office visits, particularly for people with low-wage jobs and/or complex social needs result in pregnant people often attending fewer than 14 prenatal visits. Frequently, those visits are shorter than 15 minutes.

Doulas generally work as independent contractors, whereas health care providers for the majority of Medicaid enrollees in New York City are likely to be employees of the medical centers where they work.

Doula coverage rates that appear modest but feasible in comparison to those of hospital staff, may be untenable considering doulas' added expenses. Doulas have to pay out of pocket for expenditures that salaried employees do not, either because they receive them as part of their employment arrangement such as benefits (e.g. health insurance, vacation time, etc.) and supplies, or because they do not incur them (e.g. transportation expenses of home visits and costs related to highly unpredictable work hours).

In 2018, the U.S. Department of Labor's Bureau of Labor Statistics calculated that, on average, employee benefits were valued at 46.3% of employee salaries.[29] In other words, a doula would have to pay approximately 46.3% of their income to get benefits that an employee with an equal income would obtain from their employer. This includes paid vacation time, sick leave, unemployment insurance, health and dental insurance, and retirement contributions. Health insurance alone, even when purchased on the NY State insurance exchange with subsidies, can cost hundreds to thousands of dollars a year for an individual, and nearly three times as much for a family.

On average, in 2018, the US Department of Labor reported that:

Employer-paid benefits increase employee salaries by an average of 46%.

Department of Labor Reported Averages for Civilian Employees [29]

Transportation costs in New York City add to doula's out-of-pocket expenditures. In Kings County, many doulas depend on public transportation to reach clients for home visits, adding approximately $5.50 to the cost of providing a single prenatal visit (currently billable at $30 per visit). When a client goes into labor, often in the middle of the night, safety concerns and lengthy nighttime subway waits often make a taxi the most appropriate option for reaching a client promptly. Taxi rides can surpass $20 each way, and parking fees in New York City are comparable, with street parking often unavailable. Doulas are also responsible for purchasing their own supplies, which may include a computer, printer and other equipment as well as items that cannot be reused and must be replaced or replenished after each birth.

Doulas also face added childcare costs associated with their inconsistent schedules. Doulas with children need flexible and last-minute childcare options in order to be on call at all times, because of the unpredictable timing of birth. Reasonable child care options, like group daycare, is not generally available during evenings and nights and is not usually available on a last-minute, drop-in basis.

Doula support includes significant uncompensated time outside the hours spent providing home visits or attending a birth.

Doula fees must also cover their time providing remote support by text, phone, and email, as well as un-reimbursable time spent traveling to each home visit, and the several weeks spent "on-call" around the time of the client's birth. Being on call and providing home visits at the convenience of the family can make it difficult or impossible to schedule other work into the available gaps, inevitably creating pockets of time when the doula cannot schedule paid work.

RATES DO NOT CONSTITUTE A LIVING WAGE AND ARE NOT EQUITABLE

Fee-for-service reimbursement rates would not meet the benchmark set by New York City's minimum wage.

Community-based doulas would receive the equivalent of $5.58 per hour for each 2-hour home visit in New York, when including travel time, subway costs, and benefits.

New York State plans to reimburse each prenatal and postpartum visit at $30 per visit. Paying on a fee-for-service basis is the norm under Medicaid. Both private and community-based doulas are also generally paid either in a fee-for-service model or at a set rate for a package of services. While an hourly minimum wage is not directly applicable in a fee-for-service context, an hourly minimum wage can serve as a benchmark when determining appropriate rates.

Community-based doulas spend about two hours with a client when conducting each home visit.[iv] Time may be spent providing information, education, and emotional support; performing needs assessments; preparing the client and planning for labor, childbirth, breastfeeding, and parenting; building trust with the client; making and following up on referrals; screening for depression, intimate partner violence, and food insecurity; providing lactation support and information; supporting reproductive life planning; assisting with and educating about newborn care; and fostering bonding and attachment between baby and family members. These responsibilities require a significant investment of time.

New York City's minimum wage is $15.00 for employers with more than 11 employees and $13.50 for employers with 10 or fewer employees in 2019, increasing to $15.00 in 2020. Given that a prenatal visit with a doula lasts 2 hours, the fee would just meet the minimum wage if the visit were performed in an office. However, because travel to a home visit costs a minimum of $5.50 for a round trip on the subway or bus, once a doula pays out of pocket for public transportation, the compensation falls to $24.50 for two hours, or just $12.75 an hour. That calculation excludes the hour of round-trip travel time that is common for subway trips between 2 locations in Kings County. If a doula receives $30 for a home visit that lasts 2 hours, requires 30 minutes of travel each way, with a subway cost of $5.50 (round trip), the doula will have $24.50 after expenses for three hours of time, **the equivalent of $8.17 per hour required to complete the visit.** As addressed above, that amount would not be supplemented by employer-provided benefits. Accounting for employee benefits valued at 46.3% of employee salaries,[29] $8.17 per hour without benefits is the equivalent of a full time job that pays **$5.58 per hour plus benefits.**

Medicaid fees fall well below rates in existing Kings county community doula programs.

Three local programs currently compensate community-based doulas providing support for members of low-income communities and communities of color in New York City: Ancient Song Doula Services (ASDS), funded through private grants and donations; Healthy Women Healthy Futures (HWHF), funded by New York City Council; and the By My Side Birth Support Program (BMS), which receives federal funding and operates as part of Healthy Start Brooklyn. In those programs, doulas are paid for prenatal and postpartum

[iv] While the state has not set a required length of time for home visits, that is how long ASDS, VBI, and HWHF programs allot based on their experience operating community-based doula programs, and this length of time is consistent with the operation of other similar programs.

visits, and attendance at the birth at rates between nearly 2 to 3 times those proposed by the state. (See Table 3).

Currently, other Kings County based programs cover between 3 and 5 prenatal visits and 3 to 10 postpartum visits as well as attendance at the birth. Hourly compensation for doulas ranges from $25 per hour for HWHF to $37.50 per hour for BMS doulas with over a year of experience. Compensation for the birth alone ranges from $400 for a new doula with less than a year of experience at BMS to $500 for an experienced doula at BMS and all HWHF doulas, to $575 at ASDS.

The total rates of compensation for the three programs range from $900 to $1,555 for a full complement of services. The total number of hours doulas in these programs spend with clients ranges between 34 hours (assuming an average length of labor of 18 hours) and 57 hours, which amounts to 6 to 11 times the total amount of time a health care provider in a clinic and hospital setting would spend with a patient. (See Table 2). ASDS has the highest total payment, but BMS and HWHF cover additional services or costs for the doulas that either reduce out of pocket expenditures or provide additional income. HWHF covers travel costs to home visits, monthly program meetings, and births (including taxis for late-night travel), and BMS pays doulas $35/hr for attendance at monthly administrative meetings, taxis to and from births late at nights, and occasional required trainings in addition to a $75 per-client fee for completing all required documentation forms and data entry.

Three Kings County community doula programs pay 1.5 to 3 times as much as NY Medicaid in the same communities.

NY State has indicated that its set reimbursement fees are based on those in Oregon and Minnesota, but those rates have been demonstrated to be too low to permit doulas to participate in areas where the cost of living is significantly lower than New York City. In Minnesota, state legislation passed the legislature in 2018 which would increase rates to $47 per prenatal and postpartum visit and to $488 for doula services during labor and birth.[30] The package of 6 home visits ($282) with the birth would total $770. However, the cost of living in New York, particularly in Kings County and other parts of New York City, is higher than Minnesota's. Moreover, the market rate for doulas in New York City, the cost of doula services ranges as high as $4,000 or more (see NYC Doula Collective and Birth Day Presence) compared with $800-$1200 in Minnesota. Coverage rates in New York should be higher to reflect those differences.

New York State programs operating with fees comparable to proposed Medicaid rates have been unsustainable.

Village Birth International and Healthy Women Healthy Futures have each previously had contracts setting service reimbursement rates between $500 and $600, and have determined from experience that those rates are too low. VBI was previously contracted by Healthy Start Syracuse to provide doula services for a total of $500 for prenatal, intrapartum, and postpartum care. After two years, that amount was increased to $600. However, doulas found even the higher amount to be insufficient, because they had to maintain other sources of income and because of the challenges of completing required billing paperwork. Similarly, Healthy Women Healthy Futures has increased rates for childbirth and home visits from $550 in 2015 to the current total of $900.

Medicaid rates fall below rates in place or proposed in other states. (See Table 3).

Higher Medicaid reimbursement rates are already being implemented and included in new legislation. Legislation introduced in Massachusetts sets the reimbursement for the episode of care at a maximum of $1,500, with rates per service not yet determined.[31]

In Los Angeles, a new pilot program recently been established to improve birth outcomes for African American women and infants. It was developed by Health Net, one of the largest Medi-Cal HMO providers in California, which is partnering with the Association for Wholistic Maternal and Newborn Health, a local community-based organization. Health-Net is covering the cost of doula services, as well as training, mentoring, and supervision for doulas from the communities to be served, as well as covering the associated administrative and overhead costs. The program aims to reduce cesarean rates, low birth weight and prematurity, and maternal stress and anxiety. The program also seeks to increase breastfeeding initiation and maternal satisfaction with the childbirth experience. Contracted reimbursement rates are $100 for each of 6 home visits and $1250 per birth.[32]

New York State notes that the New York pilot rates are above those currently in place in Oregon and Minnesota. The lower cost of living in those states make them poor comparators for New York City, but more importantly, the existing rates in Oregon and Minnesota have not led to successful implementation. The limited implementation has been primarily from community-based organizations where temporary grant funding can supplement Medicaid reimbursement.

Both Oregon and Minnesota are continuing to review and consider increases in reimbursement rates. In Oregon, a law enacted in 2017 (HB 2015) requires the Oregon Health Authority (OHA) to review and revise reimbursement rates every two years and provide an annual report to the legislature on the status of doulas in the state.[33]

EQUITABLE REIMBURSEMENT RATES ARE COST-EFFECTIVE BASED ON SHORT-TERM AND LONG-TERM BENEFITS OF DOULA CARE

Like Oregon and Minnesota, New York has recognized that the primary benefit of doula support is its potential to improve health outcomes, health equity, and respectful and satisfying care experiences. However, rising health care costs require Medicaid programs to consider the financial impact of their decisions. For community doula support to succeed, doulas must be paid an appropriate living wage, and their fees should not be limited in any way by the capacity to demonstrate cost savings. Fortunately, research demonstrates that community-based doula support results in substantial cost savings in both the short and long term, which permits doula care to be appropriately reimbursed without increasing Medicaid spending.

Support by a trained doula during labor and birth results in:

- **fewer cesareans**
- **shorter labor**
- **fewer negative birth experiences**

Cochrane Review [1]

In the US, four of every five dollars spent on childbirth related care is concentrated on the care provided during the childbirth hospital stay,[34] signaling the undervaluing of and underinvestment in the prenatal and postpartum periods. Currently, there are multiple opportunities to reduce spending during the childbirth hospital stay and avoid future medical costs, and it is the opportunity to achieve these savings that make community-based doula programs a high value model.

Studies from three states (Minnesota, Oregon and Wisconsin) have concluded that Medicaid reimbursement of doula care holds the potential to achieve cost savings even when considering just a portion of the costs expected to be averted.[4, 5, 20]

Medicaid coverage of doula support has been found to reduce spending by as much as $1450 per birth.[5] Existing studies have focused on the cost savings that are easiest to track and are realized in the short term: lower rates of preterm birth and a reduction in cesarean rates.

High rates of cesareans and neonatal intensive care unit admissions are key drivers of high maternity care costs. Both of these rates can be reduced with community-based doula support. Cesarean rates have risen by 50% over the last two decades and now account for one of every three births,[35] despite the fact that they have been associated with rising complications and no improvements in health outcomes for either the mother or the infant.[11] There is widespread recognition that this rate is too high and national quality improvement efforts are focused on bringing those rates down. Because cesareans cost approximately 50 percent more than vaginal births, a reduction in their rates will have a significant impact on reducing costs.[6]

High rates of preterm birth resulting in NICU admissions similarly lead to health care costs of at least $26 billion annually.[36] In the US, one in ten babies is born prematurely and the risk is higher for low-income communities and communities of color.[37] The additional prenatal support provided by community-based doulas has been associated with a lower risk of preterm birth and low-birthweight infants, [8] and continuous labor and birth support by a doula is linked to reductions in cesareans.[1, 2]

Eliminating spending on non-beneficial procedures, avoidable complications, and preventable chronic conditions would each contribute to significant savings that would cover the cost of doula care.

In Minnesota, in one study, women who received services from community-based doulas, including 4 prenatal visits had a 4.7% lower preterm rate compared to 6.3% of regional Medicaid beneficiaries and a 20.4% cesarean birth rate compared to 34.2%.[3] In this study, savings were associated with doula support, when doulas were reimbursed up to an average rate of $986, with numbers ranging from $929 - $1,047 across states depending on several variables.

In a second study evaluating the cost-effectiveness of doula care, researchers in Oregon designed a model to compare outcomes of women with a trained doula versus women without a doula using a theoretical cohort of 1.8 million women. In this study, having doula care saved $91 million and increased QALYs (quality-adjusted life years) for the first and second delivery by 7,227.[5] These outcomes were attributed to 219,530 fewer cesarean deliveries, 51 fewer maternal deaths, 382 fewer uterine ruptures, and 100 fewer hysterectomies. This study demonstrated a cost-effectiveness of up to $1,452 per doula-attended birth and concluded that having a trained doula during a woman's first delivery leads to improved outcomes, decreased costs, and increased QALYs. The study additionally recommends an increase in the reimbursement rate for doula care, as a way to promote better outcomes for women.

These short-term, easily-estimated cost savings -- based primarily on calculations of the reduction in spending on cesarean sections at the time of a single pregnancy and birth -- reflect just a small portion of the spending that would be avoided in the subsequent months and years. Additional savings would be expected to result from reducing unnecessary downstream spending by preventing or reducing the severity of complications and avoiding costly rehospitalizations and chronic conditions requiring long-term treatment, care, and

cost. Particular savings would be achieved by avoiding repeat cesareans, because currently 87% of births following a cesarean result in a repeat cesarean.[38]

Among the complications and costs that could be avoided with doula support are the following:

- Cesareans have been associated with an increased risk of long-term as well as short-term complications.[39, 40] The risk of severe maternal complications is three times greater following a cesarean which also results in greater chance of hospital readmission.[39] Risks are magnified in subsequent pregnancies, with the risk of several serious types of placental complication rising exponentially with each repeat cesarean.
- Systematic reviews have found that babies born via cesarean face an increased risk of breathing problems and chronic diseases such as asthma,[41] Crohn's disease,[42] Type 1 diabetes,[43] allergies,[44] autism spectrum disorder,[45] and obesity.[46]
- Care provided by trained, experienced doulas has been found to increase the establishment and duration of breastfeeding. Increasing breastfeeding has been a top public health priority because it is linked to reduction in the risk of asthma, obesity, diabetes and ear infections in babies, and the risk of heart disease, obesity, diabetes and breast and ovarian cancers in women.[47, 48]
- Studies have found that peer postpartum support (such as that provided by a community-based doula) may help identify and reduce postpartum depression and improve parent- infant interaction.[9, 49]
- Other factors that would contribute to cost savings include reduced use of epidural pain relief and instrument assisted births.

"The rapid increase in the rate of cesarean births without evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused."

– Safe Prevention of the Primary Cesarean Delivery. Consensus Statement of the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, March 2014.

In sum, eliminating spending on non-beneficial procedures, avoidable complications, and preventable chronic conditions would each contribute to significant savings that would cover the cost of doula care and contribute to health benefits that will continue well into the future.

Conclusion

Medicaid coverage of community-based doula support is increasingly recognized as a promising model to improve maternal and infant health outcomes, improve the experience of and satisfaction with care, and improve health equity, while reducing or maintaining current levels of health spending.

New York State is poised to lead growing efforts to expand coverage of community-based doula support with the Medicaid pilot, but to do so effectively and successfully, will require innovative approaches that build on and move beyond the early efforts in Oregon and Minnesota. In order to fully realize the promise of this model of support and care, attention must be paid to the details of the service model, the composition of the service provider workforce, and the circumstances under which the work is being performed.

Doulas trained through and working with community-based initiatives are the best prepared, suited, and supported to provide the specialized support required to meet the needs of clients facing complex social, economic and environmental issues. Organizations rooted in their communities and connected with other service providers are best placed to

make referrals and link clients to appropriate, nearby, specialized support services and programs.

Recognizing, engaging, and learning from leadership within communities of color is essential and community leaders should participate in program design. Accountability is an essential function of government, and processes should be established to ensure input and participation from relevant stakeholder groups, including those representing the most affected communities as well as doulas already serving those communities.

A Medicaid pilot will not succeed without community participation and engagement. A lack of partnership with community organizations may result in doulas enrolling in the pilot who are trained in a private doula model, are not connected with robust social service referral networks, and are not trusted members of the communities in which they are working. Should a future evaluation of the pilot show little impact on outcomes or disparities from entrepreneurial, non-community-based doula care, the lack of positive outcomes could be interpreted as the failure of doula care to achieve positive results, without accounting for the fact that best practices associated with a successful program design were not adopted. This in turn could jeopardize not only the future of the NY State pilot program, but efforts in other states or at the national level.

To realize the vision behind the pilot, implementation must reflect community wisdom and proven strategies for success. Implementation can be strengthened by working to identify opportunities with the State Department of Health, NY Medicaid, Medicaid MCOs, and community groups. Individuals in communities with the knowledge, skills, and influence to support community-based doula programs can make it possible for doulas to become registered and be paid at an equitable rate for seeing clients.

Concerted effort will be required to avoid repeating the barriers to participation and consequent underutilization of Medicaid reimbursement in Oregon and Minnesota, and with increased communication and building trust, strategies to move forward effectively can be developed.

Recommendations

The following recommendations reflect concrete steps that New York and other states, should adopt to best meet the needs of the intended populations, to ensure that community-based doula support is sustainable, and to successfully improve health equity. New York and other states should:

1. **Adjust reimbursement rates** to ensure that doulas have the opportunity to earn a living wage, accounting for
    - the average amount of time spent with clients at home visits and births
    - care-associated costs incurred and time required, including
        - transportation fees
        - transportation time
        - uncompensated support and communication time
        - data collection and reporting
    - program operation costs, including

    - administrative responsibilities and program management, such as time spent matching doulas with clients, managing client database, etc.
    - supervision for doulas
    - peer mentorship for doulas
    - billing assistance
    - developing the resources, information, and relationships needed to maintain a comprehensive array of referrals
    - providing continuing education and professional development for doulas
    - overhead
  - the doula's benefits, whether paid for directly by the doula or by or a community-based organization

Adequate reimbursement rates for doulas in large urban areas like New York City would be a minimum of between $1100 and $1550, depending on the number of visits provided and other work-related requirements. Additional funds should be allocated to programs in order to support program costs.

2. Collaborate with and invest in community-based doula programs to ensure that doulas enrolled in Medicaid reimbursement programs are equipped to serve communities of color and low-income communities.

3. Support best practices through the pilot design, including but not limited to establishing mechanisms to ensure:

- **Adequate training and certification** for appropriately serving Medicaid population, which must go beyond traditional doula training to include reproductive and birth justice frameworks, race equity, cultural humility, home visiting skills, and knowledge of social services
- **Doula supervision and mentorship**, specifically by those with experience with community-based doula support, home visiting, and other forms of community-based support and services
- **Peer support** for newly trained community-based doulas

4. Develop a comprehensive approach to wellness and support by ensuring organizations or agencies are equipped with the structure, relationships, and process in place to provide the network of referral resources needed to appropriately serve clients with complex social needs. Facilitate a unified approach to the services provided.

5. Provide funds to train and certify a diverse doula workforce, specifically from underserved urban and rural low-income communities, communities of color, and communities facing linguistic or cultural barriers.

6. Incorporate community engagement as an essential component to improve health equity. Implementation of the doula pilot program should include centering leadership from within communities of color with the aim of working towards equitable models of care.

7. Take active steps to raise awareness about the benefits and availability of community-based doulas among health professional groups and associations and health care, and service delivery systems to increase uptake of doula services.

Glossary

Anti-Racist Framework - An anti-racist framework seeks to examine the ways in which people are greatly affected by lived experiences of implicit bias and racial inequity. Addressing the ways institutional and systemic racism has historically and currently impacted the reproductive health for people of color is imperative to contextualizing barriers, social determinants of health and quality of life for birthing people.

Birth Justice - Birth justice is achieved when individuals are able to make informed decisions during pregnancy, childbirth, and postpartum, that is free from racism, discrimination of gender identity, and implicit bias. Birth justice requires that individuals fully enjoy their human rights regarding reproductive and childbirth-related health decisions, without fear of coercion, including coercion to submit to medical interventions, reprisal for refusal of care, and/or face the threat of inadequate medical care. Birth justice centers the intersectional and structural needs of individuals and communities.[50]

Centered Communities - Communities that have been identified as having some of the highest disparities including but not limited to socially, economically, health, and environmental inequities encompassed within large communities of people of color. Typically, referred to as marginalized communities.

Community-Based Doula - Community- based doulas are birth workers serving families within varying communities that center African descended people, Indigenous families, and people of color. Community-Based Doulas understand the importance of seeing a birthing individual, baby, and partner as a connected unit. This support is responsive to the whole birth experience and considers how physical, emotional, mental, and spiritual experiences impact pregnancy, labor, birth, and postpartum period. Community-Based Doulas serve in a human rights framework to ensure that all people and families have access to safe, dignified, and culturally relevant care geared toward elevating the platforms of health equity, reproductive justice, and all stages of maternal health.

Cultural Humility - A framework that values and affirms the potential differences between a provider and a client within language, religious beliefs or values, age, gender, race, understandings of health and illness, or sexual orientation, and it is a model focused on understanding a client's health concerns, experiences, and preferences for care. Cultural humility encourages developing an attitude of not knowing and learning from the patient.

Full-Spectrum Doula: A full spectrum doula is a trained professional who provides comprehensive emotional, educational, advocacy, and physical support throughout an individual's reproductive lifespan, prenatally, during childbirth, and postpartum, including all pregnancy outcomes, including abortion, miscarriage, and adoption. All through an intersectional lens that incorporates a reproductive justice and birth justice framework.

Health Equity - The opportunity for all people to reach their highest attainable level of health. Health equity requires ensuring that all people have full and equal opportunities that enable them to lead healthy lives, including removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[51]

Intergenerational Trauma - The transmission of trauma from survivors to subsequent generations.

Intersectionality - The interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.

Implicit Bias - Unconscious attitudes, reactions, stereotypes, and categories that affect behavior and understanding.[52]

Maternal Toxic Zones - an area where it is unsafe to be pregnant or parenting including because birth outcomes for women and infants are worse than in neighboring areas; any area where a woman herself would not feel comfortable being pregnant, breastfeeding, or parenting.[53]

Perinatal Community Health Workers - Trusted members of the community they serve providing information and support related to pregnancy, childbirth, and infant care. PCHWs bridge language and cultural gaps and may serve as health navigators or liaisons between clients and service providers, connecting families with social, economic and health care resources that support pregnant people during the childbearing year. The goal of the PCHW is to reduce barriers to care by promoting a dialogue of cultural humility and reciprocity.

Reproductive Justice - The term "reproductive justice" was coined in 1994 by U.S. women of color who attended the International Conference on Population and Development in Cairo. It has since become a critical framework for understanding the intersections of reproductive oppression that women experience, both individually and as members of distinct communities. Reproductive justice aims to transform inequalities so that "all people have the social, political, and economic power and resources to make healthy decisions" about their "gender, bodies, sexuality, and families." This includes the right to have children, to not have children, to parent one's children, and to control one's birthing options. [54]

Race Equity - The condition where one's race identity has no influence on how one fares in society. "A Race Equity lens centers place environment and social determinants. It also addresses intergenerational and cumulative effects of racism and aggravated risks for specific local challenges."[55, 56]

Birth Equity - The assurance of the conditions of optimal birth for all people, with a willingness to address racial and social inequalities in a sustained effort.[57]

Structural Racism - The systems in which public policies, institutional practices, cultural representations, and other norms and ideologies work in various, often reinforcing ways to generate or perpetuate racial group inequity. Structural racism is not something that a few people or institutions choose to practice and does not require individual intent or action. Instead it has been a feature of the social, economic, and political systems in which we all exist.[58]

Trauma Informed Care - An organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.[59]

Community-Based Doula Model (CBD) - An expanded care model that includes preconception, interconception and pregnancy-related care. Incorporating up to seven (or even more) prenatal visits, labor assistance, and extensive postpartum visits based on birth outcome for up to one year of the child's life. CBD programs are based in underserved communities, are explicitly developed to meet the needs of communities of color and low-income communities, and often hire doulas from the communities they will be serving.

Traditional Doula Model (TDM): Typically, traditional doula models provide one to two prenatal visits, labor and birth support, immediate postpartum support, and one to two postpartum home visits.

End Notes

1. Bohren, M.A., et al. *Continuous support for women during childbirth.* Cochrane Database of Systematic Reviews, 2017(7).
2. Health Connect One. *The Perinatal Revolution* 2014 Chicago, IL
3. Kozhimannil, K.B., et al. *Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery.* Birth (Berkeley, Calif.), 2016. 43(1): p. 20-27.
4. Chapple, W., et al. *An economic model of the benefits of professional doula labor support in Wisconsin births.* Wmj, 2013. 112(2): p. 58-64.
5. Greiner, K.S., et al. *A Two-Delivery Model Utilizing Doula Care: A Cost-Effectiveness Analysis [25C].* Obstetrics & Gynecology, 2018. 131: p. 36S-37S.
6. Strauss, N., Sakala, C., and Corry, M.P. *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health.* J Perinat Educ, 2016. 25(3): p. 145-149.
7. Hodnett, E.D., et al. *Continuous support for women during childbirth.* Cochrane Database Syst Rev, 2011(2): p. Cd003766.
8. Thomas, M.-P., et al. *Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population.* 2017. 21(1): p. 59-64.
9. Trotter, C., et al. *The Effect of Social Support during Labour on Postpartum Depression.* 1992. 22(3): p. 134-139.
10. Strauss, N., Giessler, K., and McAllister, E. *How Doula Care Can Advance the Goals of the Affordable Care Act: A Snapshot From New York City.* J Perinat Educ, 2015. 24(1): p. 8-15.
11. American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine. *Obstetric care consensus no. 1: safe prevention of the primary cesarean delivery.* Obstet Gynecol, 2014. 123(3): p. 693-711.
12. New York State Department of Health. *Maternal mortality rate per 100,000 live births.* 2017; Available from: https://www.health.ny.gov/statistics/chac/birth/b33.htm.
13. New York City Department of Health and Mental Hygiene. *Pregnancy-Associated Mortality: New York City, 2006-2010.* 2015: New York, NY
14. New York City Department of Health and Mental Hygiene. *New York City Severe Maternal Morbidity, 2008-2012.* 2016: New York, NY
15. Centers for Disease Control and Prevention. *Infant Mortality Rates by Race and Ethnicity.* 2016; Available from: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm.
16. New York State Maternal Mortality Review Team. *New York State Maternal Mortality Review Report 2012-2013* 2017 Available from: https://www.health.ny.gov/community/adults/women/docs/maternal_mortality_review_2012-2013.pdf.
17. Shultz, R., Lenkiewicz, B.K., and Gupta, I. *Onondaga County Community Health Assessment and Improvement Plan 2016-2018.* 2017.
18. Black Mamas Matter Alliance and Center for Reproductive Rights. *Black Mamas Matter: A toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care.* 2018 Center for Reproductive Rights: New York, NY
19. Amnesty International. *Deadly Delivery: The Maternal Health Care Crisis In the USA.* 2010: Amnesty International Publications.
20. Kozhimannil, K.B. and Hardeman, R.R. *Coverage for Doula Services: How State Medicaid Programs Can Address Concerns about Maternity Care Costs and Quality.* Birth, 2016. 43(2): p. 97-9.
21. Horan, H. *Personal Communication* March 13, 2019.
22. Everson, C., Crane, C., & Nolan, R *Advancing Health Equity for Childbearing Families in Oregon: Results of a Statewide Doula Workforce Needs Assessment.* 2018 Oregon Doula Association Estacada, OR.
23. MN Department of Human Services. *Doula Services* 2016; Available from: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_190890.
24. Van Berkel, J. *Gov. Mark Dayton vetoes tax, spending bills.* 2018; Available from: http://www.startribune.com/gov-mark-dayton-vetoes-tax-spending-bills/483469211/.
25. Shah, N.T. *Eroding Access and Quality of Childbirth Care in Rural US CountiesEroding Access and Quality of Childbirth Care in Rural US CountiesEditorial.* JAMA, 2018. 319(12): p. 1203-1204.
26. Centers for Disease Control and Prevention. *National Ambulatory Medical Care Survey: 2010 Summary Tables.* 2010; Available from: https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2010_namcs_web_tables.pdf.
27. Kotelchuck, M. *An evaluation of the Kessner Adequacy of Prenatal Care Index and a proposed Adequacy of Prenatal Care Utilization Index.* Am J Public Health, 1994. 84(9): p. 1414-20.
28. Lane, S. *Personal Communication* February 5, 2019 & March 8, 2019.
29. U.S. Bureau of Labor Statistics. *Employer Costs for Employee Compensation news release text.* Economic News Release 2018; Available from: https://www.bls.gov/news.release/ecec.nr0.htm.

30. Office of the Revisor of the Statutes. *HF 2178 as introduced - 90th Legislature (2017 - 2018)*. 2018; Available from: https://www.revisor.mn.gov/bills/text.php?number=HF2178&version=latest&session=90&session_number=0&session_year=2017.
31. Miranda, L. and Sabadosa, N.L. *House No. 1182 An Act relative to Medicaid coverage for doula services*. 2019; Available from: https://malegislature.gov/Bills/191/H1182.Html.
32. Hanna, C. *Personal Communication* February 28, 2019.
33. Oregon Live. *HouseBill 2015*. 2017 Available from: https://gov.oregonlive.com/bill/2017/HB2015/.
34. Truven Health Analytics. *The Cost of Having a Baby in the United States*. 2013; Available from: https://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby1.pdf.
35. Hamilton, B.E., et al. *Births: Preliminary data for 2014.*, National Vital Statistics Reports, Editor. 2014, National Center for Health Statistics: Hyattsville, MD.
36. Institute of Medicine (US) Committee on Understanding Premature Birth and Assuring Healthy Outcomes, *Societal Costs of Preterm Birth* in *Preterm Birth: Causes, Consequences, and Prevention.*, B.A. Behrman RE, Editor. 2007.
37. Centers for Disease Control and Prevention. *Premature Birth* 2018; Available from: https://www.cdc.gov/features/prematurebirth/index.html.
38. Martin JA, et al. *Births: Final data for 2017*, in *National Vital Statistics Reports,*. 2018, National Center for Health Statistics,: Hyattsville, MD.
39. Connection, C. *Vaginal or cesarean birth: What is at stake for women and babies? A best evidence review*. 2012; Available from: http://transform.childbirthconnection.org/wp-content/uploads/2013/02/Cesarean-Report.pdf.
40. Gregory, K.D., et al. *Cesarean versus vaginal delivery: whose risks? Whose benefits?* Am J Perinatol, 2012. 29(1): p. 7-18.
41. Thavagnanam, S., et al. *A meta-analysis of the association between Caesarean section and childhood asthma.* Clin Exp Allergy, 2008. 38(4): p. 629-33.
42. Li, Y., et al. *Cesarean delivery and risk of inflammatory bowel disease: a systematic review and meta-analysis.* Scand J Gastroenterol, 2014. 49(7): p. 834-44.
43. Cardwell, C.R., et al. *Caesarean section is associated with an increased risk of childhood-onset type 1 diabetes mellitus: a meta-analysis of observational studies.* Diabetologia, 2008. 51(5): p. 726-35.
44. Bager, P., Wohlfahrt, J., and Westergaard, T. *Caesarean delivery and risk of atopy and allergic disease: meta-analyses.* Clin Exp Allergy, 2008. 38(4): p. 634-42.
45. Curran, E.A., et al. *Association Between Obstetric Mode of Delivery and Autism Spectrum Disorder: A Population-Based Sibling Design Study*. JAMA Psychiatry, 2015. 72(9): p. 935-42.
46. Mueller, N.T., et al. *Prenatal exposure to antibiotics, cesarean section and risk of childhood obesity*. International Journal Of Obesity, 2014. 39: p. 665.
47. Bartick, M.C., et al. *Cost analysis of maternal disease associated with suboptimal breastfeeding*. Obstet Gynecol, 2013. 122(1): p. 111-9.
48. Stuebe, A. *The risks of not breastfeeding for mothers and infants.* Reviews in obstetrics & gynecology, 2009. 2(4): p. 222-231.
49. Dennis, C.-L., et al. *Effect of peer support on prevention of postnatal depression among high risk women: multisite randomised controlled trial.* 2009. 338: p. a3064.
50. Ancient Song Doula Services. *Full Spectrum Doula Training*. 2018; Available from: https://www.ancientsongdoulaservices.com/training.
51. Health Equity Institute. *Defining Health Equity* Available from: https://healthequity.sfsu.edu/content/defining-health-equity.
52. Kirwan Institute for Study of Race and Ethnicity. *Defining Implicit Bias*. 2015; Available from: http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/.
53. Commonsense Childbirth: National Perinatal Taskforce. *What is a Materno-toxic Area?* ; Available from: https://perinataltaskforce.com/frequently-asked-questions/.
54. Ross, L. *What is Reproductive Justice?" in Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change* Available from: https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051.
55. Equity in the Center. *Terms* Available from: https://equityinthecenter.org/whoweare.
56. Crear-Perry, J. *Systems and Policies Driving Black Maternal Health Inequities.* 2018 New York Maternal Mortality Summit 2018; Available from: https://nyam.org/summit-resources/.
57. National Birth Equity Collaborative. *Solutions* 2018; Available from: http://birthequity.org/about/birth-equity-solutions/.
58. The Aspen Institute. *Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis.* Available from: https://assets.aspeninstitute.org/content/uploads/files/content/docs/rcc/RCC-Structural-Racism-Glossary.pdf.
59. The Trauma Informed Care Project. *What is TIC?* . Available from: http://www.traumainformedcareproject.org.

TABLE 2:
TIME AND COMPENSATION OF KINGS COUNTY COMMUNITY-BASED DOULAS BY PROGRAM

Time + Compensation	NY Doula Pilot					Ancient Song Doula Services					By My Side Birth Support Program					Healthy Women Healthy Futures				
	# visits	hrs/ visit	hrs total	$/ visit	Total	# visits	hrs/ visit	hrs total	$/ visit	Total	# visits	hrs/ visit	hrs total	$/ visit	Total	# visits	hrs/ visit	hrs total	$/ visit	Total
Prenatal Visits	4	2	8	$30	$120	5	2	10	$70	$350	3	2	6	$75	$225	5	2	10	$50	$250
Postpartum Visits	4	2	8	$30	$120	varies	varies	18	$35/hr	$630	4	2	8	$75	$300	3/10	2	6/27	$25/hr	$150/ 675
Labor/Birth	1	18	18	$300	$360	1	18	18	$575	$575	1	18	18	$500	$500	1	18	18	$500	$500
Remote client support - phone, text, email	10	0.2	2	$0	$0	15	0.2	3	$0	$0	10	0.2	2	$0	$0	10	0.2	2	$0	$0
Time + Compensation			36 hrs		$600			49 hrs		$1,555			34 hrs		$1,025			36/ 57 hrs		$900/ 1425
Time + Compensation Including Travel																				
Time transportation - home visits + birth	9	1	9	0	0	8	1	8	0	0	8	1	8	0	0	9	1	9	0	0
Expense: Transport to home visit, round trip	8			-$5.50	-$44	7			-$5.50	-$39	7			-$5.50	-$39	8			$0	$0
Expense: Transportation to birth	1		1	-$40	-$40	1		1	-$40	-$40	1		1	-$40	-$40			1		
TOTAL incl. travel time + expenses			45 hrs		$516			58 hrs		$1,477			43 hrs		$947			46/ 67 hrs		$900/ 1425

TABLE 3:
SAMPLE COMPENSATION RATES & REIMBURSEMENT CATEGORIES FOR COMMUNITY-BASED DOULA PROGRAMS IN DIFFERENT LOCATIONS

Location	Program	Rates for Doula Services				Additional Compensation/ Reimbursement to Doulas					Payments to Programs	
		# Home Visits	Home Visit Rate	Birth Rate	Total	Paid Mentors	Meeting Time	Travel Time	Travel Expenses	Data Entry	Doula Trainings	Program Administration
NY State	NY Medicaid Pilot	8	$30	$360	$600							
Kings County	Ancient Song Doula Services	10+	$70	$575	$1,555	✓						
	By My Side Birth Support Program		$75	$500	$1,025	✓	✓		✓	✓	✓	✓
	Healthy Women Healthy Futures	8-15	$50	$500	$1,425	✓	✓		✓	✓	✓	✓
Other States	HealthNet Pilot Los Angeles, CA	6	$100	$1,250	$1,850	✓	✓				✓	✓
	Minnesota Legislation, Re-introduced 2019*	6	$47	$488	$770							
	Massachusetts Legislation, Introduced 2019*				$1,500				Explicitly included in doula fee			

* Minnesota and Massachusetts rates are those proposed in legislation that has not yet passed.

NEW YORK UNIVERSITY
LAW REVIEW

VOLUME 95 NOVEMBER 2020 NUMBER 5

ARTICLES

RACIAL DISPARITIES IN MATERNAL MORTALITY

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Racial disparities in maternal mortality have recently become a popular topic, with a host of media outlets devoting time and space to covering the appalling state of black maternal health in the country. Congress responded to this increased societal awareness by passing the Preventing Maternal Deaths Act at the tail end of 2018. The law provides states twelve million dollars annually, for five years, to fund maternal mortality review commissions—interdisciplinary collections of experts that evaluate and investigate the causes of every maternal death in a jurisdiction. Fascinatingly, although activists, journalists, politicians, scholars, and other commentators understand that the maternal health tragedy in the United States is a racial tragedy, the Preventing Maternal Deaths Act completely ignores race. Indeed, the term "race" does not appear anywhere in the text of the statute. The irony is striking: An effort to address a phenomenon that has become salient because of its racial nature ignores race entirely.

The racial irony embodied by the Preventing Maternal Deaths Act serves as an invitation to investigate not only the Act itself, but the national conversation that is currently taking place about racial disparities in maternal deaths. Indeed, in important respects, if the general discourse that surrounds racial disparities in maternal mortality is impoverished, then we should expect that the solutions that observers propose will be impoverished as well. This is precisely what this Article discovers. The analysis proceeds in four Parts.

 I am grateful to Yuvraj Joshi, Rosie Loring, and Russell Robinson for reading and critiquing earlier drafts. Thanks are also owed to participants at faculty workshops at Emory University School of Law, Florida State University College of Law, and the University of Arizona James E. Rogers College of Law, who engaged so generously with this piece. Thanks also to Simone Lieban Levine and Hayley MacMillen for truly exceptional research assistance. And thank you to *mijn perfecte echtgenoot*, Gert Reynaert, for breaking the love scale. All errors remain my own.

Part I provides an overview of racial disparities in maternal mortality, identifying the various elements that have made pregnancy, childbirth, and the postpartum period much more dangerous for black women than their white counterparts in the United States. Part II then offers critiques of the national conversation around racial disparities in maternal mortality and warns of both the marginalizing effects it may have on black women and the possibility that it will lead to blaming black women for dying on the path to motherhood.

Part III describes the Preventing Maternal Deaths Act in some detail. Part IV follows with a critique of the Act, identifying three deficiencies. First, it notes the racial erasure contained in the Act—the fact that the Act nowhere mentions the racial dimensions of the nation's maternal health debacle. It then observes the predicament created by the fact that erasing race likely was essential to the very passage of the Act. Second, it notes that because the Act does not direct the state maternal mortality review commissions to investigate the structural and institutional forces that produce excess maternal deaths in the United States, it leaves space for maternal mortality review commissions to simply blame the dead for dying. Third, it notes that the Act does no more than fund the gathering of more data about pregnancy-related deaths. However, it observes that there is a strong argument to be made that we do not need more data. We already know why women are dying, and we already know how to save them. In this way, the tragedy of maternal mortality in the United States is not a problem of information; it is a problem of political will. To the extent that Congress chose to intervene in the maternal health debacle not with policy changes, but rather with an attestation that we need more information, the Preventing Maternal Deaths Act demonstrates that we still lack the political will to make the concrete changes that will make pregnancy and childbirth safe.

INTRODUCTION

Racial disparities in maternal mortality have become a popular topic, although the problem is not at all new. Black women[1] in the United States have *always* died during pregnancy, childbirth, or shortly thereafter at higher rates than white women. Statistics compiled in the early 1900s—when epidemiologists first began to document the frequency of pregnancy-related deaths—reveal that pregnancy and childbirth were much deadlier for black women than for their white counterparts.[2] What was true at the dawn of the twentieth century remains true today.[3] However, only recently have racial

[1] While cisgender women are not the only people who can become pregnant, I use the term "woman" and "women" in this article to refer to those who can experience pregnancy. I do this solely because the data collected around maternal mortality employs the category of "woman" and "women."

[2] Population Council, *CDC on Infant and Maternal Mortality in the United States: 1900-99*, 25 POPULATION & DEV. REV. 821, 824 (1999) ("The gap in maternal mortality between black and white women has increased since the early 1900s. During the first decades of the 20th century, black women were twice as likely to die of pregnancy-related complications as white women."); *see also* Andreea A. Creanga, *Maternal Mortality in the United States: A Review of Contemporary Data and Their Limitations*, 61 CLINICAL OBSTETRICS & GYNECOLOGY 296, 298 (2018) [hereinafter Creanga, *Maternal Mortality*] (discussing trends in maternal mortality in the United States and critiquing available data).

[3] Population Council, *supra* note 2, at 824 ("Today, black women are more than three times as likely to die as white women.").

disparities in maternal mortality become the subject of national attention.[4]

Media outlets like *The New York Times*,[5] *USA Today*,[6] *ProPublica*,[7] and *NPR*[8] have all published stories in the last few years about racial disparities in maternal mortality—each endeavoring to put names and faces on the fact that three to four times as many black women as white women die annually from pregnancy-related causes.[9] Further, two of the most famous black women in the United States—if not the world—came forward with stories of having narrowly avoided death during their pregnancies. Tennis phenomenon Serena Williams published an account of developing a pulmonary embolism after the birth of her daughter.[10] She stated that her healthcare providers ignored her when she reported her symptoms. Had she not been adamant in advocating for herself, the blood clot that had formed in her lung might have killed her.[11] Further, pop star and cultural icon

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[4] The question of *why* racial disparities in maternal mortality have only recently become the subject of national attention, although they have always existed, is a topic that I intend to explore in future research.

[5] *See* Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. TIMES MAG. (Apr. 11, 2018) https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

[6] *See* Alison Yonng, *Hospitals Know How to Protect Mothers. They Just Aren't Doing It*, USA TODAY, https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartnm-hemorrhage-safety/546889002 (last updated Nov. 14, 2019) [hereinafter Yonng, *Hospitals Know How to Protect Mothers*].

[7] *See Lost Mothers*, PROPUBLICA, https://www.propnblica.org/series/lost-mothers (last visited July 4, 2020).

[8] *See Lost Mothers: Maternal Mortality in the U.S.*, NPR, https://www.npr.org/series/543928389/lost-mothers (last visited Jnly 4, 2020).

[9] Andreea A. Creanga, Carla Syverson, Kristi Seed & William M. Callaghan, *Pregnancy-Related Mortality in the United States, 2011-2013*, 130 OBSTETRICS & GYNECOLOGY 366, 372 (2017) [hereinafter Creanga et al., *Pregnancy-Related Mortality, 2011-2013*] (finding the pregnancy-related mortality ratio from 2011–2013 to be 3.4 times as high for non-Hispanic black women as compared to non-Hispanic white women); Emily E. Petersen, Nicole L. Davis, David Goodman, Shanna Cox, Carla Syverson, Kristi Seed, Carrie Shapiro-Mendoza, William M. Callaghan & Wanda Barfield, *Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007-2016*, 68 MORBIDITY & MORTALITY WKLY. REP. 762, 762–63 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6835a3-H.pdf (finding that pregnancy-related mortality ratios from 2007–2016 were around four to five times as high for non-Hispanic black women as compared to non-Hispanic white women).

[10] Serena Williams, Opinion, *What My Life-Threatening Experience Taught Me About Giving Birth*, CNN, https://www.cnn.com/2018/02/20/opinions/protect-mother-pregnancy-williams-opinion/index.html (last updated Feb. 20, 2018, 3:32PM); *see also* Allyson Chiu, *Beyoncé, Serena Williams Open Up About Potentially Fatal Childbirths, A Problem Especially for Black Mothers*, WASH. POST (Aug. 7, 2018, 7:22AM), https://www.washingtonpost.com/news/morning-mix/wp/2018/08/07/beyonce-serena-williams-open-np-about-potentially-fatal-childbirths-a-problem-especially-for-black-mothers.

[11] *See* Chin, *supra* note 10.

Beyoncé, one of the richest black women in the world, reported that she developed preeclampsia during her pregnancy with her twins, leaving her swollen and on bed rest for a month.[12] She eventually had an emergency cesarean section (C-section) to save her life and the lives of her babies.[13] For many, the fact that both Serena Williams and Beyoncé—wealthy black women who presumably have access to the best medical care in the world—were almost felled on their paths to motherhood dramatized just how poor the state of black maternal health is in this country. As legal scholar Derecka Purnell asked in an opinion piece in *The Guardian*, "If even Beyoncé had a rough pregnancy, what hope do other black women have?"[14]

With the spotlight shining brightly on poor black maternal health outcomes, politicians hoping for the Democratic Party nomination for the 2020 presidential election articulated their positions on the issue. California Senator Kamala Harris introduced a resolution that would make the week of April 11–17 Black Maternal Health Week.[15] She also introduced an act that would incentivize healthcare providers to be trained on implicit biases, to which she attributed disparities in maternal mortality.[16] Massachusetts Senator Elizabeth Warren introduced a plan to address racial disparities in maternal mortality that involved financially rewarding hospitals with good maternal health outcomes while financially penalizing hospitals with poor outcomes.[17]

Warren, Harris, Beyoncé, and Williams are simply adding their voices to a conversation about an issue around which activists for racial justice have long agitated. These activists—keenly aware of the existence and persistence of poor maternal health outcomes for black women—have clearly articulated their view that racial disparities in

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[12] *Id.* Preeclampsia is a medical condition, usually appearing in the third trimester, that is characterized by hypertension and swelling. *See Preeclampsia*, WEBMD, https://webmd.com/baby/preeclampsia-eclampsia (last visited July 4, 2020). Preeclampsia can lead to eclampsia, which causes seizures and, possibly, brain injury and death. *See id.*

[13] *See* Chiu, *supra* note 10.

[14] Derecka Purnell, *If Even Beyoncé Had a Rough Pregnancy, What Hope do Other Black Women Have?*, GUARDIAN (Apr. 23, 2019), https://www.theguardian.com/commentisfree/2019/apr/23/beyonce-pregnancy-black-women.

[15] Press Release, Kamala D. Harris, U.S. Sen. for California, Harris, 16 Senators Introduce Resolution Designating April 11-17 as Black Maternal Health Week (Apr. 11, 2019), https://www.harris.senate.gov/news/press-releases/harris-16-senators-introduce-resolution-designating-april-11-17-as-black-maternal-health-week.

[16] *See* Press Release, Kamala D. Harris, U.S. Sen. for California, Sen. Harris Introduces Bill Aimed at Reducing Racial Disparities in Maternal Mortality (Aug. 22, 2018), https://www.harris.senate.gov/news/press-releases/sen-harris-introduces-bill-aimed-at-reducing-racial-disparities-in-maternal-mortality.

[17] *See* Elizabeth Warren, *Sen. Elizabeth Warren on Black Women Maternal Mortality: 'Hold Health Systems Accountable for Protecting Black Moms,'* ESSENCE (Apr. 30, 2019), https://www.essence.com/feature/sen-elizabeth-warren-black-women-mortality-essence.

maternal mortality are a manifestation of broader systemic racism.[18] They have insisted that the relatively impoverished state of black maternal health in the United States demonstrates the general lack of care or concern for black people in the country—a fact that they argue is apparent across multiple domains of public life.[19] For example, a *National Geographic* story covering racial disparities in maternal mortality quotes a healthcare provider and advocate who states, "[j]ust like state violence is allowing black folks to be shot dead in the street, and no one's being held accountable or even having to atone for the death of black bodies, the same thing is happening in these medical institutions."[20]

In the maelstrom of attention that has been paid of late to racial disparities in maternal mortality, Congress has acted, passing the Preventing Maternal Deaths Act at the end of 2018.[21] The law provides states twelve million dollars annually, for five years, to fund maternal mortality review committees—interdisciplinary collections of experts who evaluate every maternal death in a jurisdiction, seeking to understand why each death occurred and what can be done to prevent similar deaths in the future.[22] Although activists, journalists, poli-

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[18] *See* Morgan Brinlee, *Racism Is Literally Killing Pregnant Black Women & These Numbers Prove It*, BUSTLE (Nov. 7, 2017), https://www.bustle.com/p/race-maternal-mortality-are-linked-black-mothers-are-paying-the-price-3017625 (quoting Marsha Jones, the director of a reproductive justice advocacy organization called the Afiya Center, who described the higher rates of pregnancy-related deaths among black women as a "direct result of how black women are received when they enter the health care system that is riddled with bias about black women's bodies" (internal quotations omitted) and arguing that "[h]istorically racist ideology and practices continue to dictate how black women are treated, so even when we present with resources and access we are treated no differently than if we had no access or resources because we are still black" (internal quotations omitted)); Annalisa Merelli, *What's Killing America's New Mothers*, QUARTZ (Oct. 29, 2017), https://qz.com/1108193/whats-killing-americas-new-mothers (quoting midwife Jennie Joseph, who described the elevated rates of black maternal mortality in the United States as an effect of "racism," "classism," and "sexism").

[19] *See, e.g.*, Rachel Jones, *American Women Are Still Dying at Alarming Rates While Giving Birth*, NAT'L GEOGRAPHIC (Dec. 13, 2018), https://www.nationalgeographic.com/culture/2018/12/maternal-mortality-usa-health-motherhood.

[20] *Id.*

[21] *See* Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, 132 Stat. 5047 (2018).

[22] *Id.* § 2(d). The Preventing Maternal Deaths Act is an amendment to the Public Health Service Act, which implements the Safe Motherhood and Infant Health Initiative of the CDC. As such, the bill includes a fifty-eight million dollar figure—a sum that refers to the money allocated annually to that initiative as a whole. The bill does not indicate how much money is specifically allocated to MMRCs through the amendment. The sponsor of the bill, Representative Jaime Herrera Beutler, announced that the bill secured twelve million dollars for states to fund MMRCs. Press Release, U.S. Congresswoman Jaime Herrera Beutler, Jaime Herrera Beutler's Bipartisan Bill to Prevent Maternal Deaths Receives Committee Hearing (Sept. 27, 2018), https://jhb.house.gov/news/documentsingle.aspx?DocumentID=399310. *See also* Nina Martin, *"Landmark" Maternal Health*

ticians, scholars, and other commentators understand that the maternal health tragedy in the United States is a *racial* tragedy, the Preventing Maternal Deaths Act completely ignores race. Indeed, the term "race" does not appear anywhere in the text of the statute. The irony is striking: An effort to address a phenomenon that has become salient *because* of its racial nature ignores race entirely.

The racial irony embodied by the Preventing Maternal Deaths Act serves as an invitation to investigate not only the Act itself, but the national conversation that is currently taking place about racial disparities in maternal deaths. Indeed, in important respects, if the general discourse that surrounds racial disparities in maternal mortality is impoverished, then we should expect that the solutions that observers propose to this problem will be impoverished as well. This is precisely what this Article concludes.

The analysis proceeds in four Parts. Part I provides an overview of maternal mortality in the United States. It describes the multiple factors that have contributed to the United States attaining the status as the nation with the highest frequency of maternal deaths in the industrialized world. It then turns to an analysis of racial disparities in maternal mortality, identifying the various elements that have made pregnancy, childbirth, and the postpartum period much more dangerous for black women than their white counterparts in the United States.

After providing essential background about the issue, Part II offers three critiques of the national conversation that is currently taking place around racial disparities in maternal mortality. First, it observes the latent racism in the oft heard statement that maternal deaths should not be happening "here"—in the wealthy, resource-rich, white United States. The unstated assumption in that statement is that maternal deaths, if they are to occur, should be happening "over there"—in the (implicitly nonwhite) developing world. Second, it warns that the solutions proposed to address the problem of the excess maternal death that black women experience in the United States may have the effect of marginalizing black women even further. To be precise, black women may find themselves subjected to more surveillance and regulation in our attempts to save them. That is, in our contemporary world, *efforts to address the effects of racism carry the risk of further subordinating the victims of racism*. Third, it observes that if the general public comes to understand the problem of maternal mortality in the United States as an issue that, at bottom,

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Legislation Clears Major Hurdle, PROPUBLICA (Dec. 12, 2018) https://www.propublica.org/article/landmark-maternal-health-legislation-clears-major-hurdle.

is "about" black women, we should be prepared for the development of narratives that would blame black women for dying on the path to motherhood. Essentially, the stories that we tell about black women make it easy to fault black women for finding pregnancy difficult to survive. Following this outline of the inadequacy of the general discourse around maternal mortality in the United States, Part III then describes the Preventing Maternal Deaths Act. Part IV follows with a critique of the Act, identifying three deficiencies.

First, there is the racial erasure within the text of the Act—the Act nowhere mentions the racial character of the nation's maternal health debacle. However, attempting to depoliticize the sad state of maternal health in the nation by erasing its racial dimensions was essential to the very passage of the Act. As a point of comparison, this Part contrasts the government's "will to know" in the context of maternal mortality with the government's steadfast "will *not* to know" in the context of officer-involved homicides. The comparison underscores that when an issue is racialized, and therefore, politicized—as the issue of officer-involved homicides most certainly is—the State is much less likely to support gathering information about the phenomenon. The problem, however, is that the failure to acknowledge the maternal health tragedy as a tragedy of racial inequality limits the Act's potential to be an effective means of reducing or eliminating racial disparities in maternal mortality. If the intention is not to investigate ways to make the path to motherhood safer for *black* women, then the interventions that governments make under the Act's banner may not help black women. This is especially true because studies show that black women are dying during pregnancy, childbirth, and the postpartum period from different causes than white women.[23] The general lesson here is that *the inability to speak about racism oftentimes makes attempts to address the effects of racism ineffective*.

Second, the Act does not direct the state maternal mortality review commissions that are created by and supported with federal funds to investigate the structural and institutional forces that produce excess maternal deaths in the United States. This leaves space for the ideological commitments of those who staff state maternal mortality review commissions to guide these bodies. This means that commissions can just as easily identify the problem of maternal mortality to be structural in nature (i.e., due to low Medicaid reimbursement rates) as they can identify it to be individual in nature (i.e., due to a woman's obesity). Because the Act fails to offer guidance to states about the

[23] *See* AMNESTY INT'L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA ONE YEAR UPDATE 7 (2011) [hereinafter AMNESTY INT'L, ONE YEAR UPDATE].

focus that their maternal mortality review commissions should have, the policy changes that these commissions ultimately recommend might be focused on finding shortcomings in the individuals who are dying on the path to motherhood. Simply put, maternal mortality review commissions may end up blaming the victim. That these commissions may fault women for finding pregnancy difficult to survive is especially likely given the overrepresentation of black women among the dead.

Finally, the intervention that the state has made to address maternal mortality, the Preventing Maternal Deaths Act, is misguidedly information-centered. The Act does no more than fund the gathering of data about pregnancy-related deaths. However, there is a strong argument to be made that we do not need more data. We *already* know why women are dying, and we already know how to save them. In this way, the disaster and embarrassment that is maternal mortality in the United States is not a problem of information; it is a problem of political will. Women are dying from pregnancy-related causes in the United States because the country lacks the political will to make the changes that will save women's lives. To the extent that Congress chose to intervene in the current maternal health debacle not with policy changes, but rather with an attestation that we need more information, the Preventing Maternal Deaths Act demonstrates that we *still* lack the political will to make the concrete changes that will make pregnancy and childbirth safe. A short conclusion follows.

A brief note before continuing: black women are not the only nonwhite women who die more frequently from pregnancy-related causes than white women. In fact, the maternal mortality ratios of indigenous women and Asian/Pacific Islander women are also higher than the maternal mortality ratios of white women.[24] In this way, the

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[24] *See Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm (last visited July 7, 2020) (noting that between 2011 and 2016, the ratios of maternal deaths for black non-Hispanic women, American Indian/Alaskan Native non-Hispanic women, Asian/Pacific Islander non-Hispanic women, and white non-Hispanic women, per 100,000 live births, were 42.4, 30.4, 14.1, and 13.0, respectively).

Interestingly, the maternal mortality ratio for "Hispanic women," 11.3 deaths per 100,000 live births, is lower than that for white women. *See id.* This figure should not be taken to suggest that Latinx women enjoy a racial privilege vis-à-vis white women. Rather, it should be taken to suggest that the racial categories we employ elide vast differences among those who comprise the group. In other words, while some groups of women who have been racialized as Latinx are doing incredibly well, other groups of women who have been racialized as Latinx are suffering. The MMR of 11.3 for "Hispanic women" erases that heterogeneity. *See* SUZANNE MACARTNEY, ALEMAYEHU BISHAW & KAYLA

injustice of racial disparities in maternal mortality implicates multiple categories of nonwhite women. Nevertheless, this Article focuses on *black* maternal health and *black* maternal deaths because most of the conversation around racial disparities in maternal mortality in the last few years has centered black women. Because the issue of maternal deaths has become associated with black women, maternal mortality—and racial disparities in maternal mortality—have been racialized in a particular way. This Article explores the consequences of that particular racial cast.

Further, while black, Latinx, Asian, and indigenous people are all racially unprivileged vis-à-vis white people, the forms of each group's racial unprivilege differ from the forms of other groups' racial unprivilege. That is, while all of these groups have been racialized as nonwhite, they remain *differently* racialized. This Article chooses to focus on the specific racial discourses that have attached to black women and, consequently, the specific forms that racial disadvantage takes for this group. To do otherwise and to speak about "nonwhite women" broadly might problematically elide the heterogeneity of the group when it comes to maternal health.

I
MATERNAL MORTALITY IN THE UNITED STATES

In the United States, approximately two women die from pregnancy-related[25] causes every day, with some seven hundred preg-

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FONTENOT, CENSUS BUREAU, POVERTY RATES FOR SELECTED DETAILED RACE AND HISPANIC GROUPS BY STATE AND PLACE: 2007-2011 4 (2013) https://www2.census.gov/library/publications/2013/acs/acsbr11-17.pdf (showing that while the poverty rate among Cuban-Americans approximated 15%, the poverty rate among Americans with backgrounds from Puerto Rico and the Dominican Republic approximated 25%). The same, of course, is true for all other racial groups. *Compare* KARTHICK RAMAKRISHNAN & FARAH Z. AHMAD, CTR. FOR AM. PROGRESS, STATE OF ASIAN AMERICANS AND PACIFIC ISLANDERS SERIES 90 (2014), http://aapidata.com/wp-content/uploads/2015/10/AAPIData-CAP-report.pdf (explaining that the poverty rates for Hmong- and Bangladeshi-Americans (who are racialized as Asian) are 27% and 21.1%, respectively) *and* Bic Ngo & Stacey J. Lee, *Complicating the Image of Model Minority Success: A Review of Southeast Asian American Education*, 77 REV. EDUC. RES. 415, 419 (2007) (explaining that fewer than half of Hmong- and Cambodian-Americans have completed high school based on data from the 2000 U.S. Census), *with* PEW RESEARCH CTR., THE RISE OF ASIAN AMERICANS 18 (2013) (explaining that 70% and 51% of Indian-Americans (who are racialized as Asian) and Chinese-Americans, respectively, have a college degree or higher, and that the median income of their households is approximately $88,000 and $65,000, respectively).

[25] Experts define a pregnancy-related death as resulting "from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy." *Pregnancy-Related Deaths*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm (last visited July 6, 2020). Some authorities define "pregnancy-related" as death occurring within a year after the end of the

nant women or new mothers dying every year.[26] These numbers are notable for many reasons. First, that seven hundred women in this country die annually while attempting new motherhood means that the likelihood that a woman will not survive pregnancy and childbirth is much greater in the United States than in the countries that the United States tends to consider its peers. Indeed, the maternal mortality ratio (MMR) in the United States—23.8 deaths per 100,000 live births[27]—is approximately twice the MMR found in the United Kingdom and Canada.[28]

Second, seven hundred women dying on the path to motherhood annually in the country means that the United States is currently a deadlier place to be pregnant and give birth than it was in the recent past.[29] That is, the MMR in the United States has been steadily increasing over the course of the last quarter century.[30] In fact, the

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pregnancy. *See id.* Other authorities, like the World Health Organization, limit that time frame to six weeks. *See* World Health Organization, *Maternal Mortality Ratio (Per 100 000 Live Births)*, WHO, https://www.who.int/healthinfo/statistics/indmaternalmortality (last visited July 6, 2020). Thousands of pregnant women die annually from causes that cannot be directly attributed to their pregnancies—namely suicide and homicide. Christie Lancaster Palladino, Vijay Singh, Jacquelyn Campbell, Heather Flynn & Katherine J. Gold, *Homicide and Suicide During the Perinatal Period: Findings from the National Violent Death Reporting System*, 118 OBSTETRICS & GYNECOLOGY 1056, 1061 (2011) ("[P]regnancy-associated homicide and suicide each account for more deaths than many other obstetric complications . . . ."). The frequency of these pregnancy-*associated* deaths—which are a broader category of deaths than pregnancy-*related* deaths—have led some researchers to call for a greater focus on psychosocial health during the perinatal period. *See* AMNESTY INT'L, ONE YEAR UPDATE, *supra* note 23, at 24.

[26] Emily E. Petersen, Nicole L. Davis, David Goodman, Shanna Cox, Nikki Mayes, Emily Johnston, Carly Syverson, Kristi Seed, Carrie K. Shapiro-Mendoza, William M. Callaghan & Wanda Barfield, Ctrs. for Disease Control & Prevention, *Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017*, 68 MORBIDITY & MORTALITY WKLY. REP. 423, 423 (2019) [hereinafter Petersen, *Vital Signs*] ("Approximately 700 women die annually in the United States from pregnancy-related complications.").

[27] Maternal mortality ratios refer to the number of pregnancy-related deaths per 100,000 live births.

[28] John A. Ozimek & Sarah J. Kilpatrick, *Maternal Mortality in the Twenty-First Century*, 45 OBSTETRICS & GYNECOLOGY CLINICS NORTH AM. 175, 176–77 (2018) (noting that "the current MMR in the United States is almost 2 times greater than that of the United Kingdom and more than 2 times greater than the MMR in Canada").

[29] The United States first began tracking its MMR in 1900, when eight hundred women died of pregnancy-related causes for every 100,000 live births. *See* Creanga, *Maternal Mortality*, *supra* note 2, at 298. However, the MMR dropped precipitously in 1920, after the discovery of penicillin. *See id.* (noting that a "monotonic decline in maternal mortality . . . coincides with the introduction of penicillin in 1928"). The United States' MMR was at its lowest in 1998, when only seven women died of pregnancy-related causes for every 100,000 live births. *See id.* Since 1998, it has been generally increasing. *Id.*

[30] Some have observed that the apparent increase in the United States' MMR may not be owed entirely to an increased frequency of maternal deaths, but may also be attributed to improvements in identifying maternal deaths. For one, states added a standardized

United States is one of just thirteen countries that have experienced an uptick in its MMR over the past twenty-five years.[31] Moreover, the United States is the *only* developed country among this ignominious thirteen.[32] The other 158 countries where pregnancy-related deaths have been tracked—countries hailing from both the developed and developing world—managed to reduce their MMRs in the last quarter century.[33]

Third, that seven hundred women die of pregnancy-related causes in the United States annually is remarkable when one considers the large sums of money spent on healthcare every year in the country—specifically healthcare concerning pregnancy and childbirth.[34] As one commentator notes, the ninety-eight billion dollars spent on pregnancy-related healthcare is a "shockingly poor return on investment"[35] in light of the hundreds of maternal deaths annually.

Fourth, that seven hundred women die in the United States of pregnancy-related causes annually is significant because researchers

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pregnancy checkbox on death certificates in 2003, decreasing the likelihood that a deceased woman's recent pregnancy would go unrecorded. Anna E. C. Daymude, Andrea Catalano & Dave Goodman, *Checking the Pregnancy Checkbox: Evaluation of a Four-State Quality Assurance Pilot*, 46 BIRTH 648, 649 (2019). Additionally, the International Classification of Diseases was revised in 1999, improving the coding of disease and death and thereby increasing the likelihood that a death from pregnancy-related causes will be flagged as such. Nat'l Ctr. for Health Statistics, *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/icd/icd9cm.htm (last visited July 5, 2020). Nevertheless, many observers have argued that although some of the recorded increase in MMR in the United States may be owed to improvements in tracking pregnancy-related deaths, we can still safely conclude that, at the very least, the United States has not reduced its MMR in the last twenty-five years—unlike the overwhelming majority of nations in the world. *See* Creanga, *Maternal Mortality*, *supra* note 2, at 299 ("Despite a level of uncertainty around actual mortality levels, without question, the risk of death during and shortly after pregnancy from pregnancy-related causes has not declined in the United States for more than 25 years."); Ozimek & Kilpatrick, *supra* note 28, at 176 ("Of the 171 countries studied by the United Nations Maternal-Mortality Estimation Inter-Agency Group, 158 demonstrated a reduction in maternal mortality over the 25 years studied.").

31 *See* Ozimek & Kilpatrick, *supra* note 28, at 176.

32 These thirteen nations are the "Bahamas, Georgia, Guyana, Jamaica, North Korea, St. Lucia, Serbia, South Africa, Suriname, Tonga, United States, Venezuela, and Zimbabwe." *Id.*

33 *Id.*

34 *See* CTR. FOR REPROD. RIGHTS, SISTERSONG, & THE NAT'L LATINA INST. FOR REPROD. HEALTH, REPRODUCTIVE INJUSTICE: RACIAL AND GENDER DISCRIMINATION IN U.S. HEALTH CARE 12 (2014) [hereinafter REPRODUCTIVE INJUSTICE] (noting that the "U.S. spends an estimated $98 billion per year on hospitalization during pregnancy and childbirth—twice as much as any other country").

35 Debra Bingham, Nan Strauss & Francine Coeytaux, *Maternal Mortality in the United States: A Human Rights Failure*, 83 CONTRACEPTION 189, 189 (2011).

estimate that more than half of these deaths are preventable.[36] That is, these deaths are not "inevitable"—an unfortunate, but unavoidable, consequence of pregnancy and childbirth.[37] The preventability of maternal deaths is evident in the fact that there is significant variation in MMRs across states. Some states have impressively low MMRs—like California, where only seven women die from pregnancy-related causes for every 100,000 live births.[38] Other states have terribly high MMRs—like Louisiana, where seventy-eight women die from pregnancy-related causes for every 100,000 live births.[39] The significant variation in MMRs across states has led at least one group of researchers to assert that the risk of dying from pregnancy-related causes "is not a 'natural' distribution," but rather the result of "state-by-state policies."[40]

What is true at the state level is true at the national level. Just as states can implement policies to reduce MMR, so too can the United

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[36] *Pregnancy-Related Deaths*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/vitalsigns/maternal-deaths (last visited Feb. 17, 2020) ("About 3 in 5 pregnancy-related deaths could be prevented.").

[37] *See* Rebecca J. Cook & Bernard M. Dickens, *Upholding Pregnant Women's Right to Life*, 117 INT'L J. GYNECOLOGY & OBSTETRICS 90, 90 (2012) (stating that oftentimes, a "fatalistic" view that women simply will not "survive their pregnancies" can be found everywhere, including in those countries that are not "resource-poor").

[38] *CA-PAMR (Maternal Mortality Review)*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, https://www.cmqcc.org/research/ca-pamr-maternal-mortality-review (last visited Feb. 17, 2020). Notably, the MMR in California used to be much higher, at 16.9 deaths per 100,000 live births in 2006. *Id.*; *see* Creanga, *Maternal Mortality*, *supra* note 2, at 303. In order to address the issue, a consortium of several stakeholder organizations known as the California Maternal Quality Care Collaborative developed "patient safety bundles" that help healthcare providers identify and manage the risks that their pregnant and postpartum patients face. *What We Do*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, https://www.cmqcc.org/about-cmqcc/what-we-do (last visited Feb. 17, 2020). Observers credit the drastic reduction of the MMR in California to the Collaborative's work. *See* Creanga, *Maternal Mortality*, *supra* note 2, at 303.

[39] In Louisiana, the MMR among black women is 72.6 per 100,000 live births, while the MMR among white women is 27.3. Casey Leins, *States with the Highest Maternal Mortality Rates*, U.S. NEWS (June 12, 2019), https://www.usnews.com/news/best-states/articles/2019-06-12/these-states-have-the-highest-maternal-mortality-rates.

[40] YALE GLOB. HEALTH JUSTICE P'SHIP, WHEN THE STATE FAILS: MATERNAL MORTALITY & RACIAL DISPARITY IN GEORGIA 5 (2018); *see also* CTR. FOR REPROD. RIGHTS, BLACK MAMAS MATTER: ADVANCING THE HUMAN RIGHT TO SAFE AND RESPECTFUL MATERNAL HEALTH CARE 10 (2018), http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf [hereinafter BLACK MAMAS MATTER] ("[P]oor maternal health outcomes are not inevitable, but are instead the result of laws, policies, and institutional practices that can be changed."). *But see* Amirhossein Moaddab, Gary A. Dildy, Haywood L. Brown, Zhoobin H. Bateni, Michael A. Belfort, Haleh Sangi-Haghpeykar & Steven L. Clark, *Health Care Disparity and Pregnancy-Related Mortality in the United States, 2005–2014*, 131 OBSTETRICS & GYNECOLOGY 707, 707 (2018) (observing that the variation in MMRs across states "may simply be a product of differences in the prevalence of medical risk factors for poor perinatal outcomes").

States nationally. Thus, if the risk of dying during pregnancy, childbirth, or shortly thereafter is twice as high in the United States as in the nations that we tend to think of as its peers, it is due to the United States' failure to do what is necessary to make pregnancy and childbirth less deadly. This is a task that, while not at all easy, is achievable.[41] As some commentators have observed, "[m]aternal mortality is not principally a medical problem; it is primarily a social problem and a problem of political will . . . ."[42] Hundreds of women in the United States die preventable deaths every year "not because we do not know how to save them,"[43] but because we simply have not made the effort to do so. Legal scholars Rebecca Cook and Bernard Dickens have made this point cogently, arguing that we have not made pregnancy and childbirth safe in the United States because we live in a

> political culture that perceives the need for national defense in only a military context, not in a health context. If countries and governments suffered their rates of maternal mortality due not to inadequate maternity services but to military aggression, they would consider themselves under major attack, and allocate their resources to effective defense.[44]

Which is to say: if seven hundred people died annually from terrorist attacks within the borders of the United States, the efforts to prevent these deaths would far exceed what the nation is currently doing to prevent the deaths of the seven hundred women who die annually from pregnancy-related causes.

Notably, while maternal mortality is a problem in the United States, rates of maternal morbidity are even higher. Severe maternal morbidity refers to cases in which a pregnant or recently postpartum woman faces a life-threatening diagnosis or must undergo a life-saving medical procedure—like a hysterectomy, blood transfusion, or

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[41] This is to say that although most of the pregnancy-related deaths in the United States are preventable, the reasons for them are complicated. *See* BUILDING U.S. CAPACITY TO REVIEW AND PREVENT MATERNAL DEATHS: REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES 35 (2018), https://reviewtoaction.org/sites/default/files/national-portal-material/Report%20from%20Nine%20MMRCs%20final_0.pdf [hereinafter REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES] ("[C]ircumstances leading to maternal death are complex and multifactorial; no one contributing factor is likely sufficient to result in a death. On average, four contributing factors were identified for each pregnancy-related death . . . .").

[42] Alicia Ely Yamin, *Toward Transformative Accountability: Applying a Rights-Based Approach to Fulfill Maternal Health Obligations*, 7 SUR INT'L J. HUM. RTS. 95, 112 (2010); *see also* Laura Katzive, *Maternal Mortality and Human Rights*, 104 INT'L LAW TIME CHANGE 383, 383 (2010) ("The persistently high number of maternal deaths every year, despite so much knowledge about how to prevent them, requires us to look at this problem as a failure of political will—a failure that reflects women's low status around the world.").

[43] Yamin, *supra* note 42, at 112.

[44] Cook & Dickens, *supra* note 37, at 91.

mechanical ventilation—to avoid death.[45] For every maternal death in the country, there are close to one hundred cases of severe maternal morbidity.[46] As one might expect, the risk of a woman suffering from severe maternal morbidity, like the risk of a woman dying from a pregnancy-related cause, has steadily increased over the past few decades.[47]

A. Causes of Maternal Mortality

One might conceptualize the causes of maternal mortality either narrowly or broadly. A narrow framing would approach the issue technically, focusing on the medical conditions that have led to maternal deaths. Meanwhile, a broad framing would focus on the social conditions that have made it difficult for women to survive pregnancy and childbirth.

1. Looking Narrowly

When researchers approach the causes of maternal mortality narrowly, they observe that a third of pregnancy-related deaths in 2006–2009 were due to a condition involving the cardiovascular system.[48] The other leading causes of maternal deaths are "other medical noncardiovascular disease," infection, and hemorrhage.[49] While some medical conditions that have contributed to pregnancy-related deaths are exceedingly difficult to avoid and treat—amniotic fluid

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[45] *See* Elizabeth A. Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 CLINICAL OBSTETRICS & GYNECOLOGY 387, 388 (2018) [hereinafter Howell, *Reducing Disparities*] (describing trends and disparities in maternal morbidity in the United States); *Severe Maternal Morbidity in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last updated Jan. 31, 2020) (providing descriptions and trends in severe maternal morbidity).

[46] Howell, *Reducing Disparities*, *supra* note 45, at 488.

[47] *See id.* (noting that "[s]evere maternal morbidity . . . in the United States . . . has been on the rise over the last few decades"); Katherine Ellison & Nina Martin, *Nearly Dying in Childbirth: Why Preventable Complications Are Growing in U.S.*, NPR (Dec. 22, 2017, 12:17 PM), https://www.npr.org/2017/12/22/572298802/nearly-dying-in-childbirth-why-preventable-complications-are-growing-in-u-s ("[T]he rate at which women are suffering nearly fatal experiences in childbirth has risen faster than the rate at which they're dying. Based on the rate per 10,000 deliveries, serious complications more than doubled from 1993 to 2014 . . . .").

[48] *See* Andreea A. Creanga, Cynthia J. Berg, Jean Y. Ko, Sherry L. Farr, Van T. Tong, F. Carol Bruce & William M. Callaghan, *Maternal Mortality and Morbidity in the United States: Where Are We Now?*, 23 J. WOMEN'S HEALTH 3, 5 (2014).

[49] Ozimek & Kilpatrick, *supra* note 28, at 178. This represents a departure from past eras, during which the leading causes of maternal mortality included hypertensive disorders, blood clots, and hemorrhage. *See id.* at 177.

embolism, for example[50]—the deaths that result from the medical conditions that constitute the leading causes of maternal mortality are much more preventable.[51] A report released by nine maternal mortality review commissions states that approximately 68.2% of deaths involving cardiovascular disease and 70% of deaths involving hemorrhage could have been avoided.[52]

Others have argued that the relatively high MMR in the United States, and the fact that it has been increasing steadily over the course of the past several decades, is attributable to the women who are becoming pregnant. More precisely, this explanation for the United States' comparatively high MMR looks to the increased prevalence among women of reproductive age in the country of chronic conditions, like heart disease, hypertension, obesity, and diabetes.[53] These chronic conditions increase the risk of pregnancy complications.[54] Accordingly, if more women enter pregnancy with one or more of these chronic conditions, more women will suffer from pregnancy complications—and more women will die from them. However, this explanation does not hold up against analysis, as researchers have shown that other nations have managed to reduce their MMRs despite the increased incidence of chronic conditions among women of reproductive age in those countries.[55] Sections II.C. and IV.B. return to patient-focused explanations of maternal mortality.

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[50] *See* REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 25 (noting that "embolism deaths are considered one of the least preventable among pregnancy-related deaths"); Nina Martin, Emma Cillekens & Alessandra Freitas, *Lost Mothers*, PROPUBLICA (July 17, 2017) [hereinafter Martin et al., *Lost Mothers*], https://www.propublica.org/article/lost-mothers-maternal-health-died-childbirth-pregnancy (observing that "up to 80 percent of mothers who develop amniotic fluid embolisms die").

[51] The CDC defines a death as preventable when it "may have been averted by one or more changes in the health care system related to clinical care, facility infrastructure, public health infrastructure, and/or patient factors." *See* Creanga, *Maternal Mortality*, *supra* note 2, at 302 (citing CTRS. FOR DISEASE CONTROL & PREVENTION, STRATEGIES TO REDUCE PREGNANCY-RELATED DEATHS: FROM IDENTIFICATION AND REVIEW TO ACTION (Cynthia Berg et al. eds., 2001)).

[52] REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 22.

[53] *See* Ozimek & Kilpatrick, *supra* note 28, at 177–78 (discussing studies conducted in the United States that showed an increase in chronic conditions as well as maternal mortality). Other patient-focused explanations of the comparatively high MMR in the United States assert that maternal deaths may be attributed to patients failing to report "warning signs" or "symptoms requiring health care assessment" to their providers. REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 35.

[54] *See* Creanga, *Maternal Mortality*, *supra* note 2, at 299.

[55] *See, e.g.*, INST. FOR HEALTH METRICS & EVALUATION, THE GLOBAL BURDEN OF DISEASE: GENERATING EVIDENCE, GUIDING POLICY 20 (2013) (illustrating the rising disease burden from noncommunicable causes in, among other regions, North America, Central Asia, and Europe from 1990 to 2010); *Maternal Mortality: Key Facts*, WORLD HEALTH ORG. (Sept. 19, 2019), https://www.who.int/news-room/fact-sheets/detail/

2. *Looking Broadly*

If we look beyond the narrow, clinical explanations of maternal mortality in the United States that solely focus on medical conditions that lead to death, we would see the healthcare system upon which pregnant women and new mothers rely. Some researchers with this broadened focus have attributed the comparatively high MMR in the United States to the surfeit of medical interventions during labor and childbirth that have become de rigueur in the country.[56] Many observers have concluded that the typical birth in the United States is medically managed to an excessive extent.[57] Moreover, they have concluded that the country's comparatively high MMR is due to this excess.[58] However, other researchers disagree. They have been careful to note that although the rate of C-sections in the United States is high and many C-sections are unnecessary, we ought not to conclude that the nation's comparatively high MMR is attributable to its C-section rate. Instead, the medical condition that causes a pregnant

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maternal-mortality (naming Central Asia and Europe as two subregions that have dramatically reduced their MMRs since 2000). Other explanations similarly do not hold up against analysis. Some have attributed the United States' high MMR to its large rural population—a population that might have to travel long distances to medical facilities, decreasing their ability to access medical care when faced with an obstetric emergency. *See* Moaddab et al., *supra* note 40, at 710. Yet, "Canada, a nation which is even more rural, has a maternal mortality ratio less than half of the United States'—10 per 100,000 live births." *Id.*

[56] For example, it is not at all unusual for a pregnant woman to have her labor induced, which may necessitate the use of drugs, like Pitocin, to enhance the labor and strengthen contractions. *Inducing Labor*, AM. PREGNANCY ASS'N, https://americanpregnancy.org/labor-and-birth/inducing-labor (last visited July 4, 2020). The use of oxytocin (known by its brand name Pitocin) may have the effect of making the ensuing contractions unbearable, leading many laboring women to request an epidural. *See id.* (noting the existence of various measures to relieve pain during delivery). An epidural may slow or stop a pregnant woman's labor, which may require more medical interventions—the most dramatic of which is a cesarean delivery. *See* Bupesh Kaul, Manuel C. Vallejo, Sivam Ramanathan, Gordon Mandell, Amy L. Phelps & Ashi R. Daftary, *Induction of Labor with Oxytocin Increases Cesarean Section Rate as Compared with Oxytocin for Augmentation of Spontaneous Labor in Nulliparous Parturients Controlled for Lumbar Epidural Analgesia*, 16 J. CLINICAL ANESTHESIA 411, 412–13 (2004) (describing the results of a study that found a higher rate of cesarean deliveries among women whose labor was induced).

[57] *See* Bingham et al., *supra* note 35, at 191 (stating that in the United States, "women and infants are often exposed to more procedures than are medically necessary or beneficial"); Merelli, *supra* note 18 (quoting an obstetrician who describes maternity care in the United States as "over-medicalized" and noting that the "[e]xcessive interventions" that are part and parcel of this over-medicalization "carry serious additional risks").

[58] *See* Bingham et al., *supra* note 35, at 191 (arguing that the "overuse of medical procedures increases injuries"); Erin K. Duncan, *The United States' Maternal Care Crisis: A Human Rights Solution*, 93 OR. L. REV. 403, 407 (2014) ("Medical interventions are at times necessary in birth. . . . However, when such interventions are used without clear evidence-based indications that the expected benefits will outweigh the potential harms, they can negatively impact women's health.").

woman's death may be what makes a C-section medically indicated. As one set of researchers explains, the correlation between a C-section and a maternal death "does not reflect causation; the overwhelming majority of maternal deaths associated with cesarean delivery is a consequence of the indication for the cesarean delivery, not the operation itself."[59]

Other researchers with a broadened approach to understanding the causes of maternal mortality attribute the United States' high MMR to the lack of postpartum care for women who have recently given birth. Many maternal deaths—especially those that are caused by infection, blood clots, and hemorrhage—occur some period of time after the woman has delivered her baby.[60] In order to avoid these deaths, recently postpartum women must be monitored, and they must have access to healthcare after their infant has been born. However, "[m]ost health plans in the United States only cover a single visit to a health care provider around 6 weeks after birth unless the woman has a recognized complication."[61] The United States' parsimonious approach to postpartum care stands in stark contrast to the approach that many European nations take, in which "multiple home visits following birth are standard for all women."[62]

Other researchers looking broadly at the question of the causes of maternal deaths in the United States have concluded that the high MMR in the country is due to the government's failure to oversee and regulate hospitals and healthcare providers. Many hospitals have not implemented measures that are known to identify pregnancy complications and prevent death.[63] California managed to cut its MMR in half over the course of just a few short years by training healthcare providers and hospital staff to identify and respond to potentially life-threatening conditions in their pregnant or recently postpartum patients.[64] These practices, which hospitals throughout the state implemented, have been "endorsed by leading medical societies as the

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[59] Moaddab et al., *supra* note 40, at 710.

[60] *See* Bingham et al., *supra* note 35, at 190.

[61] *Id.*

[62] *Id.*

[63] Alison Young, *Mothers Are Dying. Will This Bill Help?*, USA TODAY (Dec. 19, 2018), https://www.usatoday.com/story/news/investigations/deadly-deliveries/2018/12/19/maternal-mortality-rate-bill-targets-childbirth-deaths/2339750002 [hereinafter Young, *Mothers Are Dying*] (stating that many healthcare providers "fail[ ] to follow nationally promoted best practices that make childbirth safer"); BLACK MAMAS MATTER, *supra* note 40, at 44 (noting that "an appropriate clinical response" can often prevent death and severe injury when pregnancy complications develop, yet "not all providers and facilities are prepared to recognize and respond to these complications").

[64] Young, *Hospitals Know How to Protect Mothers*, *supra* note 6.

gold standard of care."[65] Although these safety measures are now well-known[66]—and although their efficacy has been proven—many hospitals outside of the state have failed to put them into practice. For example, safety experts in California recommend that whenever women develop elevated blood pressure readings, they should immediately be given a medication that will bring down their blood pressure to safe levels.[67] However, "[a]t dozens of hospitals in New York, Pennsylvania, and the Carolinas . . .[,] fewer than half of maternity patients were promptly treated for dangerous blood pressure that put them at risk of stroke. At some of those hospitals, less than 15 percent of mothers in peril got recommended treatments . . . ."[68] If the government regulated hospitals with an interest in patient safety and quality of healthcare, it could require that hospitals follow "the gold standard of care."[69]

It is undeniable that the disjointed character of healthcare financing and delivery in the United States makes government oversight and regulation of hospitals and healthcare providers difficult. Regulation of healthcare in a single-payer system is simple—a fact to which some have attributed the low MMR in the United Kingdom.[70] In contrast, in the United States, "[t]he fragmented nature of health care financing and delivery also leads to a fragmented and uncoordinated approach to oversight. The federal government's involvement in reducing maternal mortality and addressing disparities lacks coordination; efforts are split between a number of federal agencies."[71] Nevertheless, some observers have concluded that the federal government is fully capable of regulating hospitals and healthcare providers when it

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[65] *Id.*

[66] *See id.* ("[S]ome of [the safety practices] have been known for at least eight years.").

[67] Tom Archer, Maurice Druzin, Laurence E. Shields & Nancy Peterson, California Maternal Quality Care Collaborative, *Antihyperintensive Agents in Preeclampsia*, *in* CMQCC PREECLAMPSIA TOOLKIT 3 (2013), https://www.cmqcc.org/resource/2825/download.

[68] Young, *Hospitals Know How to Protect Mothers*, *supra* note 6.

[69] *Id.*

[70] *See id.* (stating that some experts believe that the single payer system in Great Britain is responsible for the fact that women die from pregnancy-related causes at a third of the United States' rate, as "[i]n countries with publicly funded national health care systems . . . it is easier to insist hospitals and health providers follow standard safety practices").

[71] AMNESTY INT'L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 85 (2010) [hereinafter AMNESTY INT'L, DEADLY DELIVERY]. The report goes on to explain that "[w]hile litigation provides an avenue for individuals or families to seek redress, it rarely leads to systemic reform. Even when improved procedures and policies do result from such litigation, they are often piecemeal and localized." *Id.*

comes to maternal healthcare quality, despite "[t]he fragmented nature of healthcare delivery and financing"[72] in the United States.[73]

B. Racial Disparities in Maternal Mortality

As noted above, the official MMR in the United States is 23.8 deaths for every 100,000 live births.[74] However, this figure obscures the fact that not all women in the United States are similarly situated when it comes to the likelihood that they will not survive pregnancy, childbirth, or the postpartum period. To be precise, the path to motherhood is significantly deadlier for black women than it is for their white counterparts. This is not to say that surviving pregnancy and childbirth is a sure shot for white women in the United States: Women in twenty-four other industrialized nations have better chances of avoiding a pregnancy-related death than white women in the United States.[75] Nevertheless, black women in the United States have even worse chances of surviving pregnancy than their white counterparts.

Black women are three to four times as likely to die from pregnancy-related causes than white women.[76] This racial disparity in maternal mortality has persisted across the generations.[77] Indeed, the gap has "widened."[78] Eighty years ago, black women were twice as likely as white women to die on the path to motherhood.[79] Thirty years ago, black women were three times as likely as white women to die.[80] Presently, black women are nearly four times as likely to die as their white counterparts.[81]

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[72] *Id.*

[73] *See* Young, *Hospitals Know How to Protect Mothers*, *supra* note 6 (noting that the Centers for Medicare and Medicaid Services could condition funds on the recipient hospital's or provider's implementation of safety measures, as they do for certain surgeries and other medical services).

[74] Marian F. MacDorman, Eugene Declercq, Howard Cabral & Christine Morton, *Recent Increases in the U.S. Maternal Mortality Rate, Disentangling Trends from Measurement Issues*, 128 OBSTETRICS & GYNECOLOGY 447, 453 (2016).

[75] AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 1.

[76] *See* Petersen, *Vital Signs*, *supra* note 26, at 423–24 (reporting findings that black women have a pregnancy-related mortality ratio 3.3 times as high as that of white women); *see also* Creanga et al., *Pregnancy-Related Mortality, 2011-2013*, *supra* note 9, at 372 (reporting findings of a ratio of 3.4 for same).

[77] *See* YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 16 (describing how this disparity has existed—and grown—since the Centers for Disease Control and Prevention have begun to record this information in 1940).

[78] *See* Howell, *Reducing Disparities*, *supra* note 45, at 387 (noting that racial disparities in maternal deaths have "widened over the last hundred years" (citations omitted)).

[79] YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 16.

[80] *Id.*

[81] AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 19.

Clinicians report that black women are dying from different causes than white women. While cardiovascular and coronary conditions, cardiomyopathy, and hemorrhage are among the most frequent causes of death for both groups of women, deaths from embolism as well as preeclampsia and eclampsia are much more common among black women than white women.[82] Interestingly, the high numbers of deaths that black women suffer from preeclampsia and eclampsia appear to be, on the whole, avoidable. "Over a three-year period, the United Kingdom had only two deaths from preeclampsia and eclampsia, suggesting deaths from these hypertensive disorders of pregnancy are highly preventable."[83] In essence, the technology and knowledge that could save black women's lives exist. The United States simply has not deployed them.

That three to four times as many black women die from pregnancy-related causes as white women hides that there is significant variation in racial disparities in maternal mortality across cities and states. In other words, place matters. In New York City, a study of the period from 2006 to 2010 found that the MMR for black women is 56.3, while the ratio for white women is 4.7—making black women in the city twelve times more likely to die from a pregnancy-related cause than their white counterparts.[84] In Fulton County, Georgia, which includes Atlanta, the MMR for black women is ninety-four deaths per 100,000 live births, while the ratio for white women is "too insignificant to report at all."[85] The MMR for black women in D.C. is one of the highest in the country;[86] meanwhile, the MMR for white women in D.C. is the *lowest* in the country—disturbing statistics that reveal that "[e]xcellent care is apparently available but is not reaching all the people."[87] Dramatic racial disparities in maternal mortality are

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[82] REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 16–17. Deaths from infection and "[m]ental health conditions" were much more common among white women. *Id.*

[83] *Id.* at 6. For definitions of preeclampsia and eclampsia, see *supra* note 12.

[84] LORRAINE C. BOYD, TAMISHA JOHNSON, AILEEN LANGSTON, CANDACE MULREADY-WARD & JUAN PEÑA, N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, PREGNANCY-ASSOCIATED MORTALITY, NEW YORK CITY, 2006-2010, at 5, 9 (2010) https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf ("Black, non-Hispanic women were 12 times more likely than White, non-Hispanic women to die from pregnancy-related causes between 2006 and 2010."). Racial disparities in maternal deaths have widened in NYC, as black women were just seven times more likely than their white counterparts to die from pregnancy-related causes from 2001 to 2005. *Id.* at 5. Fascinatingly, "[t]he increasing gap was largely driven by a 45% decrease in pregnancy-related mortality among White, non-Hispanic women." *Id.*

[85] REPRODUCTIVE INJUSTICE, *supra* note 34, at 13.

[86] *See id.*

[87] Moaddab et al., *supra* note 40, at 711. The overall MMR in D.C.—a site in which black people comprise half of the population—is 41.6 deaths per 100,000 live births;

not unique to D.C., New York, or Georgia. "[I]n some areas of Mississippi, . . . the rate of maternal death for women of color exceeds that of Sub-Saharan Africa, while the number of White women who die in childbirth is too insignificant to report."[88] Specifically, in Chicksaw County, Mississippi, 595 black women die from pregnancy-related causes for every 100,000 live births—a statistic that reveals that black women in the county would have a better chance at surviving birth if they lived in Kenya or Rwanda—poor, underdeveloped nations where the MMR is 400 and 320, respectively.[89]

There may be a tendency to attribute racial disparities in maternal mortality to socioeconomic status. That is, it is no secret that black people disproportionately bear the burdens of poverty in the country.[90] Many may assume that racial disparities in maternal mortality are a function of the disproportionate poverty in which black people live.[91] The assumption may be that black women are more likely to suffer a maternal death because more black women live in poverty, and poverty, of course, is known to compromise the health of those forced to live in it.[92] If true, then racial disparities in maternal mortality are, at bottom, merely class-based disparities in maternal

meanwhile, the national average MMR is 28. REPRODUCTIVE INJUSTICE, *supra* note 34, at 13.

[88] REPRODUCTIVE INJUSTICE, *supra* note 34, at 6.

[89] *Id.* at 13 (citation omitted). Across Mississippi, the MMR for black women is fifty-four deaths for every 100,000 live births—a figure that is almost twice the MMR for white women in the state. BLACK MAMAS MATTER, *supra* note 40, at 21. The result is that "a Black woman in Mississippi is more likely to suffer a maternal death than a woman in Palestine, Mexico, or Egypt." *Id.*

[90] *See Poverty in America Continues to Affect People of Colour Most*, ECONOMIST (Sept. 26, 2019) https://www.economist.com/special-report/2019/09/26/poverty-in-america-continues-to-affect-people-of-colour-most ("Across America, black people remain disproportionately poor. More than 20% live in poverty, twice the rate of whites."); *see also* AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 25 ("Women of color are at least twice as likely as white women to be living in poverty; approximately a quarter of black and Latina women have incomes below the Federal Poverty Level . . . ." (citation omitted)).

[91] *See, e.g.*, Adi Hirshberg & Sindhu K. Srinivas, *Epidemiology of Maternal Morbidity and Mortality*, 41 SEMINARS PERINATOLOGY 332, 335 (2017) ("While exact causes of these disparities are not completely understood, current hypotheses include multiple risk factors such as . . . less education, later initiation to prenatal care, . . . and lower insurance coverage among some of these populations." (citations omitted)); Daniel B. Nelson, Michelle H. Moniz & Matthew M. Davis, *Population-Level Factors Associated with Maternal Mortality in the United States, 1997-2012*, 18 BMC PUB. HEALTH 1007, 1012 (2018) ("Many factors likely play a role in perpetuating [racial disparities in maternal mortality], including poor access to prenatal care and lower educational attainment . . . ." (citations omitted)).

[92] *See* Jane Goodman & Claire Conway, *Poor Health: When Poverty Becomes Disease*, U.C.S.F. (Jan. 6, 2016), https://www.ucsf.edu/news/2016/01/401251/poor-health-when-poverty-becomes-disease (quoting the Chief of University of California San Francisco's Division of Developmental Medicine within the Department of Pediatrics as saying

mortality. But this logic is incorrect. In truth, *racial disparities in maternal mortality ratios persist across income levels and education status*.[93] Black women with class privilege are dying at higher ratios than white women with comparable class privilege. As obstetrician and activist Joia Crear-Perry explains it, "[a]s a black mother, I cannot buy or educate my way out of dying at 3 to 4 times the rate of a white mother in the United States."[94] Indeed,

> [a] White woman with less than a high school education has a better chance to live in childbirth than a Black woman with a college degree . . . . [A] Black woman who initiates prenatal care in the first trimester has a worse outcome in birth than a white woman with late or no prenatal care.[95]

In essence, higher levels of income and education are not protecting black women attempting motherhood.

As discussed above, there are significant variations in MMR across states and cities.[96] Significantly, these variations closely correlate with the racial composition of the sites. Thus, states and cities with larger numbers of black people tend to have high MMRs; conversely, states and cities with smaller numbers of black people tend to do better when it comes to MMR.[97] Accordingly, when a state boasts that it is one of the safest places in the country to be pregnant and give birth, the state's claim may be true simply because there are fewer

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"[s]ocioeconomic status is the most powerful predictor of disease, disorder, injury and mortality we have").

[93] *See, e.g.*, Margaret A. Harper, Mark A. Espeland, Elizabeth Dugan, Robert Meyer, Kathy Lane & Sharon Williams, *Racial Disparity in Pregnancy-Related Mortality Following a Live Birth Outcome*, 14 ANNALS EPIDEMIOLOGY 274, 274 (2004) ("After controlling for gestational age at delivery, maternal age, income, hypertension, and receipt of prenatal care, African-American race remained a significant predictor variable."); CRISTINA NOVOA & JAMILA TAYLOR, EXPLORING AFRICAN AMERICANS' HIGH MATERNAL AND INFANT DEATH RATES, CTR. FOR AM. PROGRESS 4 (Feb. 1, 2018), https://www.americanprogress.org/issues/early-childhood/reports/2018/02/01/445576/exploring-african-americans-high-maternal-infant-death-rates ("Numerous studies show that after controlling for education and socioeconomic status, African American women remain at higher risk for maternal and infant mortality.").

[94] *Better Data and Better Outcomes: Reducing Maternal Mortality: Hearing on H.R. 1318 Before the Subcomm. on Health of the Comm. on Energy & Commerce*, 115th Cong. (2018) (statement of Joia A. Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative), https://docs.house.gov/meetings/IF/IF14/20180927/108724/HHRG-115-IF14-Wstate-CrearPerryJ-20180927.pdf.

[95] *Id.*; *see also* Howell, *Reducing Disparities*, *supra* note 45, at 390–91 (discussing a study that "found the largest racial disparity among women with the lowest risk of pregnancy-related disease" (citation omitted)).

[96] *See* discussion *supra* notes 84–89 and accompanying text.

[97] *See* Moaddab et al., *supra* note 40, at 709 (finding "a significant correlation between state mortality ranking and the proportion of non-Hispanic black women in the delivery population and an inverse correlation with deliveries to non-Hispanic white women").

pregnant black women in the state—not because the state offers superior maternal healthcare relative to other states.[98]

1. Explaining Racial Disparities in Maternal Mortality

Researchers have identified multiple factors that likely contribute to racial disparities in maternal mortality. Notably, most of these factors are social. The weight of the research in this area establishes that the higher rates of maternal deaths among black women as compared to white women cannot fully be explained in terms of a higher prevalence among black women of risk factors that are known to lead to poor pregnancy outcomes. Differently stated, while black women are less likely to survive pregnancy and childbirth, this is not simply because black women have higher rates of obesity, diabetes, hypertension, or other chronic conditions that increase the likelihood of pregnancy complications.[99] Certainly, some of the racial disparity in maternal mortality and morbidity can be attributed to black women entering pregnancy unhealthier than their white counterparts;[100] undeniably, some of the disparity can be explained in terms of the higher rates of poverty—which, again, is known to compromise health—among black women.[101] However, these traditional risk factors for poor pregnancy outcomes do not *fully* explain higher rates of maternal death among black women. The research in this area shows that in many cases, black women are dying on the path to motherhood not because they are poor, or sick, or obese, or unable to access medical care. Rather, in many important respects, black women are dying on the path to motherhood because they are *black*.[102] In a multiple

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[98] *Id.* at 711 ("[A]lthough low state maternal mortality ratios may reflect state-specific excellence in quality, leadership, organization, and funding of obstetric health care, such favorable ranking could simply reflect a different proportion of non-Hispanic black patients in the population rather than intrinsically superior medical care. The converse applies as well.").

[99] Bingham et al., *supra* note 35, at 190 ("[C]ontrary to common assumptions, the racial and ethnic disparities in [pregnancy] outcomes are not always due to women of color having a higher prevalence of diseases.").

[100] *See* Howell, *Reducing Disparities*, *supra* note 45, at 391 ("Data suggest that a web of factors including higher prevalence of comorbidities . . . contribute to but do not fully explain the elevated rates of severe maternal morbidity and mortality among racial and ethnic minority women.").

[101] *See id.* (stating that racial disparities in maternal mortality may, in part, be attributed to black women's "lower socioeconomic status"); *see also* REPRODUCTIVE INJUSTICE, *supra* note 34, at 13 ("Socioeconomic factors . . . also drive disparities.").

[102] *See, e.g.*, AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 74 (discussing a study that found that black women were 2.5 times more likely to die from an obstetric hemorrhage than white women, although both groups of women are equally likely to suffer this complication); Bingham et al., *supra* note 35, at 189 ("[I]n a national study of five medical conditions that are common causes of maternal death and injury . . . , black women

regression analysis conducted in 2007, researchers found that racial disparities in maternal mortality

> could not be explained by other risk factors that were found to be significantly associated with adverse outcomes in univariable analysis. These included age, obesity, history of a chronic medical condition, prior cesarean delivery and gravidity. Education level, marital status and public medical insurance status, factors traditionally associated with sociodemographic status, could not explain the disparity.[103]

The balance of this Section discusses the many factors that, acting in concert, likely produce the racial disparities in maternal mortality that are so well-documented. It begins with an exploration of biological race—an explanation for racial disparities in maternal mortality, and racial disparities in health, more generally, that critical scholars have rejected, and the weight of good science has disproved. It then turns to more likely contributors to racial disparities in maternal mortality—including different rates of poverty between racial groups, stress and weathering experienced by black people, and differences in quality of care provided to black and white women.

a. Biological Race—or a Problematic, if Popular, Explanation of Racial Disparities in Maternal Mortality

The belief that there is a genetic essence to race has a long history.[104] This idea proposes that the groups that we consider to be races (i.e., black, white, Asian, indigenous, etc.) exist as such because the individuals within each group are more genetically similar to one another than they are to individuals outside of their group. This

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did not have a significantly higher prevalence than white women of any of these conditions . . . [but] were [still] two to three times more likely to die than the white women who had the same complication."); William A. Grobman et al., *Racial and Ethnic Disparities in Maternal Morbidity and Obstetric Care*, 125 OBSTETRICS & GYNECOLOGY 1460, 1461 (2015) (noting that racial disparities in maternal mortality "do not appear to be related solely to a greater prevalence or severity of obstetric complications" and that "black women are more likely to have pregnancy-associated mortality even after accounting for severity of" the complication); Howell, *Reducing Disparities*, *supra* note 45, at 390 ("[T]he increased risk of maternal death among racial and ethnic minority women appears to be, at least in part, independent of sociodemographic risk. Adjustment for sociodemographic and reproductive factors has not explained the racial gap . . . ." (citation omitted)).

[103] Dena Goffman, Robert C. Madden, E.A. Harrison, Irwin R. Merkatz & Cynthia Chazotte, *Predictors of Maternal Mortality and Near-Miss Maternal Morbidity*, 27 J. PERINATOLOGY 597, 600 (2007).

[104] *See* Elizabeth Kolbert, *There's No Scientific Basis for Race—It's a Made-Up Label*, NAT'L GEOGRAPHIC, https://www.nationalgeographic.com/magazine/2018/04/race-genetics-science-africa (Mar. 12, 2018) (describing the experiments that physician Samuel Morton performed on the skulls of differently-raced individuals in the mid-nineteenth century and noting that these experiments earned him the title of "the father of scientific racism").

notion, what we may call "biological race," offers that people who have been racialized as black share a genetic profile—that is, they have certain genes, and lack other genes—that distinguishes them from people who are not black. Further, people who have been racialized as Asian share a genetic profile that distinguishes them from people who are not Asian. And so on and so forth. Although the weight of good science disproves the existence of biological race[105]—and although history has demonstrated the terrors of the idea when lawmakers transform it into social policy[106]—the idea has persisted.[107] Indeed, otherwise respected scholars with large platforms and loud microphones have insisted that there is a biological or genetic truth about race, despite all of the sound evidence to the contrary.[108]

If there was a genetic or biological essence to race, it would go a long way towards explaining racial disparities in maternal mortality—and racial disparities in health, more generally. The racial disparities in health outcomes in the country that are so familiar to public health scholars would not be attributable to the United States' two-tiered healthcare system, which provides superior care to the haves and inferior care to the have-nots.[109] Neither could they be attributed to different, substandard treatment that healthcare providers may, intentionally or unintentionally, give their black patients. Neither could they be attributed to the disadvantage that black people have inherited—disadvantage that may have biological consequences.[110] Neither

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105 *Id.* ("Researchers who have . . . looked at people at the genetic level now say that the whole category of race is misconceived.").

106 Osagie K. Obasogie, *The Return of Biological Race? Regulating Race and Genetics Through Administrative Agency Race Impact Assessments*, 22 S. CAL. INTERDISC. L.J. 1, 4 (2012) (commenting that "the Holocaust exposed the horrors that ideas about biological race can produce"). Obasogie argues that "legal moments . . . [such as] anti-miscegenation laws, immigration laws, and eugenics . . . serve as guideposts for understanding the unholy alliance between law and science in fostering the growth of biological race." *Id.* at 9.

107 *See, e.g.*, Neil Risch, Esteban Burchard, Elad Ziv & Hua Tang, *Categorization of Humans in Biomedical Research: Genes, Race and Disease*, 3 GENOME BIOLOGY 1, 4 (2002) (arguing for the continued use of racial and ethnic categories in biomedical and genetic research because of genetic differences between racial classifications).

108 *See, e.g.*, NICHOLAS WADE, A TROUBLESOME INHERITANCE: GENES, RACE AND HUMAN HISTORY (2014) (defending the idea that races are genetically coherent entities); David Reich, *How Genetics is Changing Our Understandings of 'Race,'* N.Y. TIMES (Mar. 23, 2018), https://www.nytimes.com/2018/03/23/opinion/sunday/genetics-race.html ("[A]s a geneticist I also know that it is simply no longer possible to ignore average genetic differences among 'races.'").

109 *See, e.g.*, KHIARA M. BRIDGES, REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION 24, 26–30 (2011) [hereinafter BRIDGES, REPRODUCING RACE] (discussing the United States' two-tiered healthcare system and the inferior care offered to those on the lower tier).

110 *See* Jones, *supra* note 19 (quoting the head of the maternal and infant health division at the CDC as asserting that racial disparities in maternal mortality and morbidity might be

could they be attributed to the health consequences of the hostile environments that black people constantly navigate. Instead, racial disparities in health would be in the genes. Racial disparities in maternal mortality, specifically, would be explained by a gene or complex of genes that predisposes the black women who possess these genes to poor maternal outcomes.

It bears repeating, time and again, that no credible theory of population genetics can support the idea that black people's genes are responsible for the poor states of health that they disproportionately inhabit. As legal scholar Dorothy Roberts has written, "It is implausible that one race of people evolved to have a genetic predisposition to heart failure, hypertension, infant mortality, diabetes, and asthma. There is no evolutionary theory that can explain why African ancestry would be genetically prone to practically every major common illness."[111] Nevertheless, the idea of biological race has endured.

The literature on racial disparities in maternal mortality and morbidity is replete with references to the potential genetic underpinnings of the phenomenon.[112] Indeed, a survey of this literature suggests that even if an author ultimately rejects the idea that race has a genetic or biological essence, she has to at least gesture to the possibility that black women's genes are killing them.[113] Unfortunately, even the

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a function of "the experience of being a black woman in America[ ] and the intergenerational effects of racism and segregation," and claiming that the social and historical context in which black people live and have lived may "play[ ] out through biology"). Legal scholar Dorothy Roberts describes this idea quite clearly when she explains that race is not a biological category that has had political and social consequences. Rather, it is a social, fundamentally political category that has had biological consequences. *Dorothy Roberts: What's Race Got to Do with Medicine?*, NPR: TED RADIO HOUR (Feb. 10, 2017), https://www.npr.org/transcripts/514150399.

111 Dorothy E. Roberts, *What's Wrong with Race-Based Medicine?: Genes, Drugs, and Health Disparities*, 12 MINN. J.L. SCI. & TECH. 1, 15 (2011).

112 *See, e.g.*, Goffman et al., *supra* note 103, at 600 (refusing to dismiss biological notions of race, and stating that, whether race is understood in social or biological terms, it remains "a substantial risk factor for adverse maternal outcome"); Howell, *Reducing Disparities*, *supra* note 45, at 388 (stating that racial disparities in maternal morbidity and mortality "are complex and are the result of numerous factors including social, environmental, *biological*, *genetic*, behavioral, as well as healthcare factors" (emphasis added)).

113 Kevin Fiscella, *Racial Disparity in Infant and Maternal Mortality: Confluence of Infection and Microvascular Dysfunction*, 8 MATERNAL & CHILD HEALTH J. 45, 45 (2004) ("Exposure to lifelong stress, high rates of poverty and discrimination, unstable partner relationships, pregnancy wantedness, and urogenital tract infections, coupled with inadequate prenatal care *and possibly genetic factors* probably contribute to racial disparities in infant and maternal mortality." (emphasis added) (citations omitted)). Even articles that appear to evidence the authors' commitment to investigating the social factors that are responsible for racial disparities in health inevitably nod to the possibility that genes explain these disparities. *See* Moaddab et al., *supra* note 40, at 711 (theorizing that based on the available data, racial disparities in maternal mortality can be explained in terms of "social rather than medical or geographic factors" and asserting that "[e]xcellent

American College of Obstetricians and Gynecologists has failed to clearly and definitively reject the idea that race has a biological or genetic essence.[114]

That said, there are also clear rejections of biological race in the literature on racial disparities in maternal health.[115] For example, one study begins with the authors' clear articulation of their position that biological race is a myth and their commitment to investigating racial disparities in maternal mortality as a product of the way that we have organized society—and not a product of the unhealthy genes that black people possess. They write:

> Categories of race and ethnicity do not represent differences in individual behaviors or biology, but rather acknowledge historic inequities implicated in health outcomes. For the purposes of this article,

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care is apparently available, but is not reaching all the people," but also stating that "[e]thnic genetic differences may also be involved").

[114] The American College of Obstetricians and Gynecologists convened a committee to issue a statement about racial disparities in gynecological and obstetrical outcomes. Unfortunately, the statement generated offers a rather confused take on the nature of race. *See* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, COMM. OPINION NO. 649: RACIAL AND ETHNIC DISPARITIES IN OBSTETRICS AND GYNECOLOGY, at 1 (Dec. 2015). The opinion begins by stating, quite clearly, that "[r]ace and ethnicity represent social rather than biological constructs . . . ." *Id.* at 3. However, it goes on to say that some genes may be more prevalent in some racial groups and that these genes may be responsible for some of the racial health disparities that we observe. *Id.* ("Genetic polymorphisms associated with increased susceptibility to disease also may vary in frequency in different racial and ethnic groups." (citation omitted)). Thus, the committee statement leaves us with the contradictory proposition that race is not a genetic entity, but genetic variations may explain racial disparities in health. *See id.* ("[A]lthough race and ethnicity are primarily social constructs, the effect of common ancestral lineage on the segregation and frequency of genetic variations . . . cannot be ignored and should be considered a potential contributor to health disparities."). The statement also highlights the possibility that environments may interact with genes to produce negative effects. Thus, even if the genetic variations that increase susceptibility to disease are equally prevalent in white and nonwhite people, nonwhite people will have higher rates of disease if they more frequently are exposed to harmful environments. *See id.* ("Genetic variations, even those that do not vary in frequency among racial or ethnic groups, may enhance susceptibility to an environmental exposure that occurs more frequently in a particular racial or ethnic group."). Thus, while partly disavowing that race has a genetic essence, the committee ultimately seems to suggest that further research into the role of genetics in racial disparities in obstetric and gynecologic outcomes is warranted. *See id.*

[115] *See, e.g.*, Allison S. Bryant, Ayaba Worjoloh, Aaron B. Caughey & A. Eugene Washington, *Racial/Ethnic Disparities in Obstetrical Outcomes and Care: Prevalence and Determinants*, 202 AM. J. OBSTETRICS & GYNECOLOGY 335 (2010) (arguing for "the need to look beyond a genetic explanation for disparities in obstetrics" and discussing a CDC report that showed that "foreign-born women had better birth outcomes than their U.S.-born racial/ethnic counterparts despite later initiation of prenatal care and less education"—results that are inconsistent with a genetic basis for racial disparities in maternal health and that suggest that the social context in which nonwhite people live poses the greatest risk to their health (citation omitted)).

> we assume race and ethnicity to be social constructs closely related to the social determinants of health, rather than biological or genetic categories, as well as constructs that may intersect with health care utilization, social determinants, and medical risk to generate observable differences in maternal health outcome.[116]

These rejections of biological race intentionally seek to draw attention away from the distraction of a fantasied gene that makes pregnancy and childbirth dangerous to black women and bring the focus back to the social context in which black women are tragically, and avoidably, dying along the path to motherhood.

Those committed to eliminating racial disparities in maternal mortality believe that it is essential to retire the myth of biological race, as it gives society an excuse not to address a tragedy of its own making. Biological race allows society to throw up its hands at the problem of racial disparities in maternal mortality and claim that, as a phenomenon originating in individuals' genes, there is nothing we can do about it.

b. Less Problematic, and More Probable, Explanations of Racial Disparities in Maternal Mortality

There are three possible explanations for racial disparities of maternal mortality that are more likely. The first relates to the disproportionate burden of poverty that black people bear and their consequent decreased ability to access healthcare. The second relates to the race-based stress that black people experience and the effect of this stress on their body systems. The third relates to the inferior quality of the care that black people receive.

i. Poverty and Access

It is undeniable that the disproportionate indigence in which black people live explains some portion of racial disparities in maternal mortality—and racial disparities in health, more generally. However, it bears repeating that class cannot entirely explain racial disparities in maternal mortality.[117] This is because racial disparities in

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[116] Alexis Gadson, Eloho Akpovi & Pooja K. Mehta, *Exploring the Social Determinants of Racial/Ethnic Disparities in Prenatal Care Utilization and Maternal Outcome*, 41 SEMINARS PERINATOLOGY 308, 308–09 (2017) (citations omitted).

[117] Although class cannot entirely explain racial disparities in health, there are plenty of studies that insist that class is the sole cause of the phenomenon. *See, e.g.*, Moaddab et al., *supra* note 40, at 711 ("We conclude that the increased mortality ratios seen in the United States in recent years . . . are closely related to lack of access to health care in the non-Hispanic black population.").

maternal mortality persist across income levels.[118] Middle and upper middle class black women die from pregnancy-related causes at rates that are higher than middle and upper middle class white women.[119] Thus, racial disparities in maternal health cannot and should not be understood as a problem primarily of socioeconomic status. Race matters.

That said, the higher rates of poverty in which black people live relative to their white counterparts likely contributes to the oft-cited statistic describing black women as being three to four times more likely than white women to die from a pregnancy-related cause. This is because it is well-established that poverty has a deleterious effect on health.[120] People who are poor oftentimes live in unhealthy environments, where they are exposed to pollutants and toxins that are known to compromise health.[121] Poor people frequently are unable to afford healthy foods, leaving as their only dietary options the high-sodium, high-fat, high-sugar, low-nutritional-value foods that are inexpensive and readily available in poor neighborhoods.[122] Poor people may find healthcare inaccessible—disallowing them from either taking preventative measures to protect their health or from monitoring the medical conditions that they may have already developed.[123] To be poor is to be exposed to constant stress, which might have an independent negative effect on health, as discussed below.[124] Because people

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118 *See* Neel Shah, *A Soaring Maternal Mortality Rate: What Does It Mean for You?*, HARV. HEALTH PUB.: HARV. HEALTH BLOG (Oct. 16, 2018, 11:15 AM), https://www.health.harvard.edu/blog/a-soaring-maternal-mortality-rate-what-does-it-mean-for-you-2018101614914 ("[T]he risk [of dying during childbirth] is consistently three to four times higher for black women than white women, irrespective of income or education.").

119 Nina Martin & Renee Montagne, *Nothing Protects Black Women from Dying in Pregnancy and Childbirth*, PROPUBLICA (Dec. 7, 2017) https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth ("[E]ven relatively well-off black women . . . die or nearly die at higher rates than whites.").

120 SHELLEY PHIPPS, CANADIAN POPULATION HEALTH INITIATIVE, THE IMPACT OF POVERTY ON HEALTH: A SCAN OF RESEARCH LITERATURE 13 (2003) ("[T]here is little doubt that poverty leads to ill health.").

121 *See, e.g.*, Cheryl Katz, *People in Poor Neighborhoods Breathe More Hazardous Particles*, SCI. AM. (Nov. 1, 2012), https://www.scientificamerican.com/article/people-poor-neighborhoods-breate-more-hazardous-particles (describing a study that shows that tiny particles of air pollution have more hazardous materials in non-white and low-income communities than in affluent white communities).

122 *See generally* Angela Hilmers, David C. Hilmers & Jayna Dave, *Neighborhood Disparities in Access to Healthy Foods and Their Effects on Environmental Justice*, 102 AM. J. PUB. HEALTH 1644, 1644 (2012) (describing how a survey of fast-food locations identified that low-income neighborhoods had much greater access than high-income neighborhoods to unhealthy fast-food outlets).

123 *See* PHIPPS, *supra* note 120, at 16 (noting that individuals with very low incomes have very limited access to health, thus restricting their ability to improve their wellbeing).

124 *See* discussion *infra* Section I.B.1.b.ii and accompanying text.

of color, specifically black people, disproportionately bear the burdens of poverty in the United States, greater proportions of them have the poor health that is the known and expected consequence of poverty. Accordingly, greater proportions of people of color enter pregnancy with poverty-related chronic conditions—like diabetes, hypertension, and obesity.[125] These chronic conditions, especially when unmanaged, increase the likelihood that those who have them will suffer poor pregnancy outcomes.[126] This likely plays some role in generating racial disparities in maternal mortality.

Further, even when they are insured, poor pregnant women may find healthcare unreachable. This occurs when there are no healthcare providers close to the neighborhoods that poor people call home. It also occurs when the providers that are physically proximate to poor neighborhoods refuse to accept the Medicaid insurance on which poor people rely. This has been the case in Washington, D.C., parts of which have the highest maternal mortality ratios in the nation.[127] The obstetrics units of two hospitals that serve poor communities in D.C. had closed by 2018, and the obstetrics unit of a third limited the number of Medicaid patients that it sees.[128] Fiscal reasons prompted the ward closures—the obstetrics units were running in the red.[129] Medicaid reimbursed the hospitals at rates well under the costs that the hospitals incurred by providing services.[130] In fact, Medicaid reimbursement rates were a full third of private insurers' rates.[131] Thus, the

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125 *See* AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 6 ("Insufficient access to quality health care services over a woman's lifetime means that women are entering into pregnancy with health conditions that are untreated or unmanaged.").

126 *Id.* (noting that when women enter pregnancy with an unmanaged chronic condition, it "poses added risks for both the woman and her child" and offering as an example that women with "uncontrolled diabetes are more likely to have a miscarriage or develop pre-eclampsia" (citation omitted)); *see also* Amy Metcalfe, James Wick & Paul Ronksley, *Racial Disparities in Comorbidity and Severe Maternal Morbidity/Mortality in the United States: An Analysis of Temporal Trends*, 97 ACTA OBSTETRIA ET GYNECOLOGICA SCANDINAVICA 89, 93 (2018) ("[M]any women who died during their pregnancies, or shortly thereafter, had poorly managed chronic conditions prior to pregnancy.").

127 ROBYN RUSSELL, CAROLYN RODEHAU & PATRICIA QUINN, D.C. PRIMARY CARE ASS'N, HUMAN-CENTERED SOLUTIONS TO IMPROVE REPRODUCTIVE AND MATERNAL HEALTH OUTCOMES IN WASHINGTON, D.C. 2 (2018), http://www.dcpca.org/includes/storage/brio/files/204/The%20D.C.%20Womens%20Health%20Improvement%20Project.%209.12.18.pdf.

128 Tara Wilson, *Medicaid Approaches to Addressing Maternal Mortality in the District of Columbia*, 20 GEO. J. GENDER & L. 215, 223 (2018).

129 *See id.* at 229.

130 *See id.*

131 *See id.* at 230 (explaining that in D.C., the Medicaid "reimbursement rate for vaginal deliveries is $1,943.54 and $2,156.67 for cesarean deliveries" while the "cost to private insurers for childbirth in DC in 2016 and 2017 is $6,388 for vaginal delivery and $7,439 for cesarean deliveries").

hospitals that served poor, Medicaid-insured patients—who, because of the poverty-induced poor health, are more *expensive* to treat than more affluent, privately-insured patients—were left with a shortfall. It was in these hospitals' fiscal interest to shutter their obstetrics wards or reduce the number of pregnant Medicaid patients in their care.[132] This, in turn, leaves poor pregnant women in D.C., who are disproportionately black, "at risk for not receiving the care [that is] associated with healthy pregnancies."[133] The relationship between Medicaid reimbursement rates, the closures of obstetrics units, access to prenatal care, and racial disparities in maternal mortality and morbidity should be apparent.

ii. Stress and Weathering

In the early 1990s, public health researcher Arline Geronimus began investigating why black women who gave birth at younger ages had better health outcomes than their white counterparts; meanwhile, black women who gave birth at older ages had worse outcomes than their white counterparts.[134] In essence, the puzzle was why older age was health protective for white women, but not for black women. Geronimus concluded that stress explained the puzzle, writing that "the health of African-American women may begin to deteriorate in early adulthood as a physical consequence" of chronic stress.[135] Although many scholars panned Geronimus's research when she first published it,[136] her ideas have gained traction over the years, and scholars have looked to them to explain racial disparities in health, generally.[137]

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132 *See id.* at 229.

133 *Id.* at 223.

134 *See* Arline T. Geronimus, *The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations*, 2 ETHNICITY & DISEASE 207 (1992).

135 *Id.* at 207.

136 *See* Gene Demby, *Making the Case that Discrimination Is Bad for Your Health*, NPR: CODE SWITCH (Jan. 14, 2018, 7:00 AM), https://www.npr.org/sections/codeswitch/2018/01/14/577664626/making-the-case-that-discrimination-is-bad-for-your-health.

137 *See* Patia Braithwaite, *Biological Weathering and Its Deadly Effect on Black Mothers*, SELF (Sept. 30, 2019), https://www.self.com/story/weathering-and-its-deadly-effect-on-black-mothers/amp (citing Geronimus's research in an article about racial disparities in maternal mortality that was written for lay audiences and published in a mainstream magazine); Amy Roeder, *America Is Failing Its Black Mothers*, HARV. PUB. HEALTH MAG. (2019), https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers (stating that "Geronimus' ideas have become mainstream in the field" of public health). *See generally* Arline T. Geronimus, Margaret Hicken, Danya Keene & John Bound, *"Weathering" and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States*, 96 AM. J. PUB. HEALTH 826 (2006).

The idea is that chronic stress—measured in terms of "allostatic load"—increases the speed at which body systems deteriorate.[138] The physiologic responses to persistent stress may result in the "weathering" of body systems, making them age more rapidly.[139] One study on "chromosomal markers of aging indicate that black women ages 49-55 appear on average 7.5 'biological' years older than white women."[140] Other studies propose that chronic stress can impact the adrenal system, resulting in "obesity, hypertension, and diabetes."[141] If racism is a source of chronic stress for black people, and if chronic stress has negative physiological impacts, then racism could explain the higher rates of morbidity and mortality among black women. Indeed, weathering would explain why black women who report encountering race-based stresses are more likely to give birth to preterm infants or infants with lower birth weights than black women who do not report encountering these stresses.[142]

That said, the research on weathering and its effect on health is in its early stages. Accordingly, we will have to stay tuned to see if the research will be funded and, if so, whether investigators can determine the precise mechanisms by which racism-qua-chronic stress impacts health.[143]

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138 *See generally* Bruce S. McEwen & Teresa Seeman, *Protective and Damaging Effects of Mediators of Stress: Elaborating and Testing the Concepts of Allostasis and Allostatic Load*, 896 ANNALS N.Y. ACAD. SCI. 30 (1999).

139 *See* Geronimus et al., *supra* note 137, at 826.

140 YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 34; *see also* Nina Martin & Renee Montagne, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 7, 2017, 7:51 PM), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why (quoting Michael Lu, former head of the Maternal and Child Health Bureau of the Health Resources and Services Administration, who explains that "[a]s women get older, birth outcomes get worse. . . . If that happens in the[ir] 40s for white women, it actually starts to happen for African-American women in their 30s").

141 YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 34.

142 *See id.* at 10 ("Self-reported experiences of racism over the lifecourse and prenatal maternal stress have been linked to adverse birth outcomes such as declines in birth weight, increases in low birth weight, and higher rates of preterm delivery."). As one set of researchers explains, "[t]he search for a biological explanation [of how] . . . stress might affect preterm birth risk has led to an extensive literature . . . . It remains likely . . . that neuroendocrine pathways underlie the relationship between acute and chronic stressors on preterm birth and low birth weight risk." Bryant et al., *supra* note 115, at 337–38.

143 *See* Gadson et al., *supra* note 116, at 310 (noting that "[w]hile some have posited the potential role that stress and racism may play in endothelial damage and therefore in maternal morbidity and mortality . . . , there are no studies to our knowledge that clearly operationalize the mechanism by which stress may affect . . . adverse maternal outcomes").

iii. Quality of Care

As stated in a recent report about the racial inequities that dot the reproductive landscape, "[d]isparities in quality of care for racial minorities in the U.S. have long been documented."[144] Researchers are beginning to investigate how these long-documented disparities in quality of care may relate to racial disparities in health, and, more specifically, racial disparities in maternal mortality. Indeed, studies show that while thirty-three percent of pregnancy-related deaths of white women are deemed preventable, forty-six of pregnancy-related deaths of black women are deemed the same.[145] Investigators have concluded that more black women die preventable deaths than white women because black women are receiving inferior care.[146]

c. Individual Level

Healthcare providers may be giving their black patients inferior care,[147] which may ultimately endanger their patients' lives. In 2005, the Institute of Medicine (IOM)[148] released a report finding that people of color receive lower-quality health care than white people even when one controls for insurance status, income, age, and severity

144 REPRODUCTIVE INJUSTICE, *supra* note 34, at 13. The report goes on to explain that "[a]ccording to the 2013 National Healthcare Disparities Report, African Americans and Latinos received worse care on 40% of measures compared to Whites . . . ." *Id.*

145 AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 20.

146 *See id.* (citing a study that found a lack of quality care was a factor in more than half of preventable maternal deaths).

147 Relatedly, low-income women have reported being treated differently because they are poor or are "on Medicaid." *See* YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 11 (observing that "some women report being treated with disdain by health workers who know, or assume, that they are uninsured or on Medicaid"). Importantly, class-privileged black women have reported that their incomes and educational attainments have not guaranteed them positive interactions with OB/GYNs and other healthcare providers. When Pamela Merritt, who has been active in the fight to eliminate racial disparities in maternal mortality, was diagnosed with uterine fibroids and endometriosis, she had a disturbingly negative interaction with an OB/GYN who came at the recommendation of her work colleagues: " 'There I sat with my perfect English, wearing my expensive suits and my expensive handbag, and I walked into that office and got treated like shit,' Merritt says." Jones, *supra* note 19. Merritt recalls being told she "needed to have a baby as soon as possible, because 'most of you have had kids by now.' I was spoken to like a piece of meat by specialists who never once asked me if I was in pain." *Id.* When Merritt shared her story with her black female friends, she found her experience was not uncommon: "So many of them had experiences like mine and worse. And we were all what you would consider upper middle class." *Id.*

148 The Institute of Medicine has since been renamed the Health and Medicine Division. *See About the Health and Medicine Division*, NAT'L ACAD., https://www.nationalacademies.org/hmd/about (last visited June 19, 2020).

of conditions.[149] By "lower quality health care," the IOM meant the materially inferior care that physicians give their nonwhite patients. The IOM reported that racial minorities are less likely than white people to be given appropriate cardiac care, to receive kidney dialysis or transplants, and to receive the best treatments for stroke, cancer, or AIDS.[150] The IOM concluded by describing an "uncomfortable reality": "[S]ome people in the United States [are] more likely to die from cancer, heart disease, and diabetes simply because of their race or ethnicity, not just because they lack access to health care."[151]

The theory here is not that a substantial number of healthcare providers are bigots—people who consciously feel animus or antipathy for people of color and who act on these negative feelings by intentionally giving their patients of color inferior care. Instead, most scholars posit that differences in treatment can be attributed to providers' implicit biases—subconscious aversions or negative associations of which an individual may not be aware, but that impact the individual's behavior nonetheless.[152] The idea is that if a provider has an anti-black or pro-white implicit bias, she may unintentionally provide inferior care to her black patients and superior care to her white patients—for example, prescribing appropriate medication to her white patient with elevated blood pressure while failing to do the same for a black patient.[153] In this way, providers' implicit biases may

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[149] *See* INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 5 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003).

[150] *See id.* at 30, 52, 57, 61.

[151] INST. OF MED., ADDRESSING RACIAL AND ETHNIC HEALTH CARE DISPARITIES: WHERE DO WE GO FROM HERE? 3 (2005), http://cretscmhd.psych.ucla.edu/healthfair/PDF%20articles%20for%20fact%20sheet%20linking/Addressing_health_disparities.pdf.

[152] *See Understanding Implicit Bias*, KIRWAN INST., http://kirwaninstitute.osu.edu/research/understanding-implicit-bias (last visited June 19, 2020).

[153] Studies have shown that there are racial disparities in gynecological and obstetric treatment that extend beyond matters of life and death. For example, Asian women are more likely to be given episiotomies, although they are not more likely to have characteristics that make episiotomies medically indicated. *See* Grobman et al., *supra* note 102, at 1466 ("[T]he frequency of receiving an episiotomy was significantly higher for Asian women. The reasons for this increased utilization are not clear, because other patient characteristics, such as BMI and parity, did not account for this difference."). Further, studies document that nonwhite women are screened for sexually transmitted infections more often than white women. *See* Ngozi F. Anachebe & Madeline Y. Sutton, *Racial Disparities in Reproductive Health Outcomes*, 188 AM. J. OBSTETRICS & GYNECOLOGY S37, S41 (2003) (discussing research that showed pediatric providers in one southeastern U.S. county routinely failing to screen their "predominately white, privately insured . . . sexually active adolescent[ ]" patients for chlamydia "because they did not believe their patients to be at high risk and they associated high risk for chlamydial infection with low-income minorities"); *see also* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, COMM. OPINION NO. 649, *supra* note 114, at 3 ("[S]ocial and demographic biases have been shown to affect practitioners' recommendations for long-

contribute to racial disparities in maternal mortality and morbidity, and racial disparities in health, generally.[154] Many scholars, activists, observers, and even providers have argued that some important part of racial disparities in maternal deaths may be attributed to providers' implicit bias.[155] Indeed, one of the four initiatives that comprise New York City's thirteen million dollar effort to address the high rates of pregnancy-related deaths among women of color in the city involves "[e]ngaging relevant private and public health care providers across the City in adopting implicit bias training . . . ."[156]

Notably, scholars have observed that if the care that black patients are offered is inferior, they will sense it.[157] They may feel that their doctors are dismissing their concerns, are treating them rudely, or are simply giving them care that is different from what they imagine more privileged patients are receiving. This, in turn, may

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acting reversible contraceptive methods to women at risk of unintended pregnancies. It is unclear whether these biases also affect practitioners' recommendations for cesarean delivery or referrals for infertility." (footnote omitted)).

154 *See generally* DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE 33–54 (2015). For a discussion of the limitations of the literature around implicit biases, see KHIARA M. BRIDGES, CRITICAL RACE THEORY: A PRIMER 157–80 (2019) [hereinafter BRIDGES, CRITICAL RACE THEORY].

155 *See, e.g.*, Anachebe & Sutton, *supra* note 153, at S41 (asserting that "preformed biases and stereotypes explain a large part of the racial health disparities in this country"); AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, COMM. OPINION NO. 649, *supra* note 114, at 3 ("Evidence suggests that factors such as stereotyping and implicit bias on the part of health care providers may contribute to racial and ethnic disparities in health."); Jones, *supra* note 19 (quoting the Chief of the Maternal and Infant Health Branch in the Division of Reproductive Health at the Centers for Disease Control and Prevention, who offers that "[t]here's all kinds of implicit bias, racial and unconscious bias" that impacts how providers judge the things that their patients of color say to them); Press Office, *De Blasio Administration Launches Comprehensive Plan to Reduce Maternal Deaths and Life-Threatening Complications from Childbirth Among Women of Color*, N.Y.C. (July 20, 2018), https://www1.nyc.gov/office-of-the-mayor/news/365-18/de-blasio-administration-launches-comprehensive-plan-reduce-maternal-deaths-life-threatening (quoting Chanel L. Porchia-Albert, the founder of a Brooklyn-based organization that provides antiracist doula services to women of color, as stating that "[w]e must collectively strive to shift the narrative of birthing in NYC to one that addresses implicit bias and racism within maternal health"); *id*. (quoting Nicole Jean-Baptiste, a doula based in the Bronx who provides pregnancy and birth support to women of color, as saying that "the application of implicit bias and anti-racist trainings within maternal healthcare institutions must be at the core" of New York City's plan to reduce racial disparities in maternal mortality and morbidity).

156 Press Office, *De Blasio Administration Launches Comprehensive Plan*, *supra* note 155. The other three initiatives relate to improving the collection and analysis of information about maternal deaths, improving the quality of care provided in the city's public hospitals, and expanding education about maternal mortality and preventative healthcare among the communities most impacted. *See id*.

157 Gadson et al., *supra* note 116, at 310 (describing a study in which participants reported communication issues during prenatal care and "Black or Hispanic race/ethnicity was associated with almost three times higher odds of discrimination due to race, language, or culture").

cause patients not to heed their providers' advice and direction—or to avoid going to the doctor altogether.[158] This, of course, may contribute to racial disparities in maternal mortality.[159]

d. Systems Level

Recent research suggests that the inferior quality of the hospitals in which black women deliver their babies may partly explain racial disparities in maternal mortality and morbidity. Remarkably, seventy-five percent of black women in the country deliver their babies in just twenty-five percent of the nation's hospitals.[160] This means that there are hospitals that serve an exceedingly low number of black women, and there are hospitals that serve an exceedingly high number of black women.[161] The MMR in hospitals that serve large numbers of black women tends to be much higher than the MMR in hospitals that serve small numbers of black women.[162] Indeed, while the MMR in "high black-serving hospitals" tends to be tragic, the MMR in "low black-serving hospitals" tends to be enviable.[163] Notably, "high black-serving hospitals" provide inferior care to all those who enter: Even white women who find themselves receiving care in "high black-serving hospitals" are more likely to suffer an adverse outcome than if they had received their care in a "low black-serving hospital."[164]

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158 *See* YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 9 (stating that black women may "intentionally decide not to seek [pregnancy services] given histories of negative interactions and discrimination within formal healthcare systems"); Gadson et al., *supra* note 116, at 312 (discussing a study of 872 black women in which "delayed initiation of prenatal care was associated with endorsement of experiences of racism affecting family and community").

159 *See* Gadson et al., *supra* note 116, at 312 (observing that "distrust of the health care system . . . may be an important additional mediator in the relationship between utilization and outcomes for those at risk of disparities").

160 *See* Howell, *Reducing Disparities*, *supra* note 45, at 391 (noting that "75% of black deliveries in the United States occurred in a quarter of hospitals, whereas only 18% of whites delivered in those same hospitals").

161 As one might expect, the hospitals that serve high numbers of black women tend to serve low numbers of white women. Less than two percent of births to white women take place in these "high black-serving hospitals." *See* Elizabeth A. Howell, Natalia Egorova, Amy Balbierz, Jennifer Zeitlin & Paul L. Herbert, *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 AM. J. OBSTETRICS & GYNECOLOGY 122.e1, 122.e3 (2016) [hereinafter Howell et al., *Black-White Differences*] (noting that 1.8% of white deliveries took place in hospitals that serve a high number of black women).

162 *Id.* ("Women who delivered in high and medium black-serving hospitals had higher severe maternal morbidity rates than those in low black-serving hospitals.").

163 *See id.* at 122.e5 ("[W]hite patients at low black-serving hospitals had the lowest rates of adjusted severe maternal morbidity (12.3 per 1000 deliveries), and black patients at high black-serving hospitals had the highest rates (20.5 per 1000 deliveries).").

164 *See id.* ("We found that both black and white patients who delivered in black-serving hospitals had a higher risk of severe maternal morbidity after accounting for patient characteristics."). Unsurprisingly, the poor quality of care found in the obstetric wards at

Nevertheless, black women, who predominate in these "high black-serving hospitals," bear the brunt of the substandard care that they provide. One researcher writes that "[i]f black . . . mothers delivered in the same hospitals as white women, our simulation model estimated that they would experience 940 fewer severe morbid events, leading to a reduction of black severe maternal morbidity rates by 47.7% . . . ."[165] If true, a likely effective avenue to reducing or eliminating racial disparities in maternal mortality is to improve the quality of the care offered at the (functionally segregated) hospitals where black women find themselves giving birth in large numbers.[166]

What the above demonstrates is that there is no quick fix to the problem of racial disparities in maternal mortality. It is not a matter of ridding hospital wards of bigoted nurses or doctors. It is certainly not a matter of finding the elusive race-specific gene that predisposes black women to injury and death. The problem is complex—as is the solution. The answer to the challenge of racial disparities in maternal mortality likely begins well before the doctor-patient encounter—well before the pregnancy.[167] It involves redistributing wealth, elevating black people out of the poverty that they disproportionately bear. It involves eliminating residential segregation, enabling black people to move out of the neighborhoods that possess characteristics that compromise their residents' health—like violence, environmental hazards, underfunded and overburdened schools, food deserts, and a dearth of jobs that pay a livable wage. It involves reorganizing society such that it becomes unusual and surprising for individuals, both white and black, to develop anti-black and pro-white implicit biases. It involves reconstructing our country such that hostility is not a banality for black people—such that chronic stress does not "weather" their body systems. It, of course, involves improving the quality of care that preg-

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high black-serving hospitals can be found in other departments throughout the hospital. *See id.* at 122.e6 ("[D]isparities in receipt of appropriate care such as thrombotic therapy, angioplasty, carotid imaging, and provision of timely antibiotics for pneumonia are lower in hospitals that serve a high proportion of black women.").

165 Elizabeth A. Howell, Natalia Egorova, Amy Balbierz, Jennifer Zeitlin & Paul L. Herbert, *Site of Delivery Contribution to Black-White Severe Maternal Morbidity Disparity*, 215 AM. J. OBSTETRICS & GYNECOLOGY 143, 146 (2016).

166 *See* Howell et al., *Black-White Differences*, *supra* note 161, at 122.e5 (concluding that "quality of care at hospitals that disproportionately serve black women is lower than quality at low black-serving hospitals").

167 *See* Elizabeth A. Howell & Jennifer Zeitlin, *Improving Hospital Quality to Reduce Disparities in Severe Maternal Morbidity and Mortality*, 41 SEMINARS PERINATOLOGY 266, 267 (2017) (noting there is a limited ability to intervene during the clinical encounter in the social factors that compromise the health of people of color—like "[p]overty, lack of education, poor nutritional status, smoking, and . . . [l]iving in an area of higher crime").

nant black women receive in providers' offices and hospital delivery rooms.

Congress recently waded into the complexity that is the issue of racial disparities in maternal health with the passage of the Preventing Maternal Deaths Act. The Act is intended to address the United States' high MMR by funding state maternal mortality review commissions—bodies of experts that examine each maternal death in the state, seeking to understand why the death occurred and identifying specific interventions that might prevent similar deaths in the future.

Before exploring the Act and its shortcomings, however, the next Part critiques the current discourse surrounding racial disparities in maternal mortality. As the next Part argues, the conversation that is taking place around the issue of maternal deaths in the United States is problematic in many respects. Importantly, the inadequacies of the discourse surrounding the issue have come to inform the solutions that have been proposed. Accordingly, if the Preventing Maternal Deaths Act is a deficient tool with which to address the relatively poor state of maternal health in the United States, then this is partly due to the deficiencies in the prevailing discourse about maternal health in the United States. The next Part outlines those deficiencies.

II
Critiques of the General Discourse Around Maternal Mortality in the United States

This Part identifies three problems in the conversation that the nation is currently having about maternal deaths. First, there is a latent racism underlying the oft heard assertion that maternal mortality "shouldn't be happening here." Second, many of the proposals that have been offered to address racial disparities in maternal mortality raise the possibility that black women will be subjected to increased surveillance and regulation. And third, given the tendency of the United States to ignore the structural causes of problems in favor of blaming individual bad actors, there is a risk that racial disparities in maternal mortality will be conceptualized as a problem of black women failing to take care of themselves.

A. A Critique of the Claim that Maternal Deaths Should Not Be Happening "Here"

Ninety-nine percent of pregnancy-related deaths occur in the developing world.[168] This means that of the 295,000 women who died of pregnancy-related causes in 2017, the last year for which worldwide figures were calculated, 292,050 of them lived in a resource-poor country.[169] This makes for startling statistics, as when one report asserts, "If you are a woman in a wealthy country, your chance of dying during pregnancy is about 1 in 7,000. In Niger, it's 1 in 7."[170]

Africa, particularly sub-Saharan Africa, bears the brunt of maternal mortality. As one scholar describes it:

> At 480 deaths per 100,000 live births, the average MMR in Africa dwarfs that of other regions. The rate in the next underperforming region (East Mediterranean) is nearly one-half of Africa's. . . . The lifetime risk of maternal death in Africa is astronomical, one in sixteen, compared to one in 2800 in affluent countries.[171]

Eighty-six percent of all maternal deaths occur in Africa and Southern Asia.[172] The maternal deaths that occur in developing nations in other continents brings the percentage one point shy of perfect: Again, ninety-nine percent of the women who die of pregnancy-related causes live in the developing world.[173]

While the developing world has been described as having "catastrophically high rates" of maternal mortality, the developed world—of which the United States counts itself a member—is usually described as having a "low rate."[174]

It is important to recognize that the concept of the "developed" world is racialized, as is the concept of the "developing" world.[175]

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168 Obiajulu Nnamuchi, *Millennium Development Goal 5, Human Rights, and Maternal Health in Africa: Possibilities, Constraints, and Future Prospects*, 23 ANNALS HEALTH L. 92, 99 (2014).

169 *See Maternal Mortality: Key Facts*, WORLD HEALTH ORG. (Sept. 19, 2019), https://www.who.int/news-room/fact-sheets/detail/maternal-mortality.

170 Katzive, *supra* note 42, at 383.

171 Nnamuchi, *supra* note 168, at 98.

172 *See id.* at 99.

173 *See id.*

174 Cook & Dickens, *supra* note 37, at 91; *see also* Sofia Gruskin, Jane Cottingham, Adriane Martin Hilber, Eszter Kismodi, Ornella Lincetto & Mindy Jane Roseman, *Using Human Rights to Improve Maternal and Neonatal Health: History, Connections, and a Proposed Practical Approach*, 86 BULL. WORLD HEALTH ORG. 589, 590 (2008) (describing the chance of a woman in an "industrialized countr[y]" dying from a pregnancy-related cause as "remote, both statistically and historically").

175 *See generally* PAULETTE GOUDGE, THE WHITENESS OF POWER: RACISM IN THIRD WORLD DEVELOPMENT AND AID (2003); Christiana Abraham, *Race, Gender, and "Difference": Representations of "Third World Women" in International Development*, 2 J. CRITICAL RACE INQUIRY 4 (2015).

That is, the idea of "developed" world has acquired racial connotations, as has the idea of the "developing" world. Specifically, while the "developed" world is racialized as white, the "developing world" figures as its nonwhite counterpart.[176] In this way, to refer to the "developed" world is to refer to white nations; meanwhile, to refer to the "developing" world is to refer to nonwhite nations.

Most conceptualize maternal mortality as a problem of the developing world—in large part because the overwhelming majority of maternal deaths takes place in developing countries. As such, the problem of maternal mortality acquires the racialization of the regions where it so frequently takes place. Which is to say: The problem of maternal mortality has been racialized as nonwhite.[177] Accordingly, when commentators in the United States assert that maternal mortality should not be happening "here,"[178] they can be heard to say that an (implicitly) nonwhite phenomenon should not be happening inside of an (implicitly) white nation. Indeed, this may explain why the problem of maternal mortality has come to be thought of as a problem deserving of congressional action: The borders of the United States have been infiltrated by a nonwhite scourge.

Developing countries commonly figure as the Other in the American imaginary.[179] They are poor, while we are wealthy.[180] They are undemocratic, while we are bastions of democracy.[181] They have problematic values, ethics, and cultures; meanwhile, our values, ethics, and culture are above reproach.[182] Thus, when a nonwhite problem of the developing world finds its way into the United States, those deficient characteristics that describe the developing world—backwardness, state-mandated patriarchy, failure to be governed by democratic

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176 *See* GOUDGE, *supra* note 175, at 6 (explaining that "[g]lobal relations generally, and relations within the ambit of development and aid in particular, can be situated within the context of a white/black binary"). This racialization of "developed" and "developing" corresponds to the racialization of "western" and "nonwestern" countries, the "global North" and the "global South" and "industrialized" and "not industrialized" nations.

177 Indeed, maternal mortality may be racialized as black insofar as most maternal deaths take place in black countries—in sub-Saharan Africa—and are suffered by black women.

178 *See* Young, *Hospitals Know How to Protect Mothers*, *supra* note 6 (reporting that an administrator running a training session for hospitals on maternal mortality and morbidity stated, "[w]e're not talking about a Third World country, we're talking about us, here" and concluded, "[t]his shouldn't be happening here").

179 *See* GOUDGE, *supra* note 175, at 6 (explaining that development and aid are "perceived as peripheral to serious issues of real global concern").

180 *See id.* (describing the Western "conception that the 'Third World' is inferior in every way – economically, socially, culturally, morally –" and that "those countries" need to "get their act together" and "throw out their corrupt governments").

181 *See id.*

182 *See id.*

norms, etc.—become associated with "us." It becomes an "embarrassment."[183] And if we act hastily to purge ourselves of the problem, we can rid ourselves of the imputation that the things that happen over "there" are happening "here." It is through this lens that we can understand California Senator Kamala Harris's assertion that "[a]ccording to the CDC, Black mothers are 243% more likely to die from pregnancy or delivery complications than a white woman. *This is in America, not a developing nation.*"[184] It is through this lens that we can comprehend the statement made by Representative Jaime Herrera Beutler, the sponsor of the Preventing Maternal Deaths Act: "The numbers [of maternal deaths] are staggering. This is not the developing world. This is the United States of America."[185] If the United States of America is anything, it is not the developing world. It is not all the things that are associated with those poor, benighted, nonwhite parts of the globe.[186] Consider in this vein an argument that one scholar makes:

> The great majority of women who die as a result of pregnancy-related complications have lived lives marked by poverty, deprivation and discrimination. From the moment of their births, these girls and women often face a funnel of narrowing choices whereby they are unable to exercise meaningful agency with respect to what they will do with their lives, how much they will be educated, with whom they will partner, when they will have sex, whether they will use

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183 Martin et al., *Lost Mothers*, *supra* note 50 (noting that the failure of states and the federal government to do more to combat the high MMR in the country has been called "an international embarrassment").

184 Kamala Harris (@KamalaHarris), TWITTER, (Dec. 28, 2017, 9:18 PM) (emphasis added), http://twitter.com/kamalaharris/status/946565940183027712?lang=en.

185 Laura Ungar, *What States Aren't Doing to Save New Mothers' Lives*, USA TODAY (Nov. 14, 2019, 2:15 PM), https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/09/19/maternal-death-rate-state-medical-deadly-deliveries/547050002.

186 Sometimes the damning of developing nations, and the veneration of developed nations, occurs more explicitly, as when one scholar attributes the high MMR in Africa to the "kleptocracy" that runs governments, as well as "political cronyism, covetousness, [ ] self-aggrandizement," and bald-faced theft committed by public officials. Nnamuchi, *supra* note 168, at 137–38. This scholar explicitly compares the excess and immorality that African government officials exhibit to the noble restraint that officials in the United States exercise and impose on themselves and others. *Id.* at 137 (comparing the "brazen avarice and profligacy" of Nigerian senators making "$1.7 million in annual salaries and allowances," while American senators are paid $174,000 per annum). Nnamuchi elaborates on what accounts for this stark difference, noting that "political elites in Africa tend to think of themselves first, their associates and relatives second, and the people last. In the vast majority of the countries in the region, lavish and ostentatious lifestyles have supplanted the peoples' business, including health and health care, as the reason for seeking leadership positions." *Id.* Nnamuchi finds that this "[i]rresponsible governance [model] holds sway even as lives of pregnant women are lost daily on account of the deficit of healthcare and social or underlying determinants of health." *Id.* at 137–38.

> contraception, and finally what care they will get when they are pregnant or delivering, even when their lives hang in the balance.[187]

This description suggests that maternal mortality is not primarily a consequence of poverty. Instead, maternal mortality is principally a product of sexism and patriarchy. Women in the developing world are dying at terrifying rates from pregnancy-related causes because of the misogyny that runs rampant in the societies in which they live. The argument in this Section is that this is *not* supposed to describe the United States—a country that imagines itself to sit in diametrical opposition to *those places* where women lack basic freedoms, like the ability to attend school and get an education, freely move through public spaces, control when, whether, and with whom they have sex, and choose who they will marry. In essence, what is killing pregnant women and new mothers in the developing world is sex inequality—something that countries in the "West" purport to have ridded themselves of long ago.[188] Accordingly, the sex inequality that is supposed to describe the West's Others becomes imputed to the United States when maternal deaths proliferate within the country's borders. The suggestion that the United States is "like" its Others in any significant respect is quite a damning charge.

Further, there is an interesting racial shaming that occurs when the United States' MMR is compared to the MMRs of countries that are nonwhite and the comparison reveals that those countries are outperforming the United States. Consider a statement made by a set of researchers:

> With 99% of maternal deaths occurring in developing countries, it is too often assumed that maternal mortality is not a problem in wealthier countries. Yet, statistics released in September of 2010 by the United Nations place the United States 50th in the world for maternal mortality—with maternal mortality ratios higher than almost all European countries, *as well as several countries in Asia and the Middle East*.[189]

When one considers the racialization of maternal mortality, as well as the racialization of the developing/developed world dichotomy, one hears a racial shaming when observers point out that the United States' MMR is higher than the MMRs of some countries in Asia and

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[187] Yamin, *supra* note 42, at 95.

[188] *See* Emily Hill, *The End of Feminism*, SPECTATOR (Oct. 24, 2015), https://www.spectator.co.uk/2015/10/the-decline-of-feminism ("The totemic battles [against sexism] were hard fought — and they were won. The next generation should be encouraged to enjoy the spoils, not worry old wounds."); Danielle Paquette, *More Than Half of US Men Think Sexism is Over*, WORLD ECON. F. (Aug. 25, 2016), https://www.weforum.org/agenda/2016/08/more-than-half-of-men-in-the-us-think-sexism-is-over.

[189] Bingham et al., *supra* note 35, at 189 (emphasis added).

the Middle East: Several *nonwhite* countries are doing a better job at expunging a nonwhite phenomenon from their borders.[190] Meanwhile, the United States—developed, white—sits 50th on the list of nations ranked by their prevalence of a killer of nonwhite women.[191]

Of course, there is a place for comparisons with other nations. Indeed, there is a compelling claim that international comparisons are essential to racial progress in this country. Professor Derrick Bell has argued that if the Civil Rights Movement achieved gains for black people, it was not simply because powerful white people in the nation found black people's demand for equal treatment and full citizenship morally compelling.[192] Bell's argument is that the Civil Rights Movement was a success—insofar as formal racial equality was achieved—because it was in the country's interest to acknowledge black people's dignity and humanity in light of the Cold War and the threat that Russia posed to the United States' global dominance.[193]

As Bell contends, and historian Mary Dudziak explores more extensively,[194] the United States and the Soviet Union were pitted in a heated battle for influence and power on the world stage after the end of the violent conflict of World War II.[195] During this time, the United States asserted that it was the superior nation—and countries should ally themselves with it—because while privation, communism, and a disturbing lack of freedom characterized the Soviet Union, abundance, democracy, and liberty described the United States.[196] However, the Soviet Union gave the lie to the United States' portrayal of itself by bringing attention to the reality that a significant portion of the United States' citizenry was destitute and living under a pro-

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[190] *See also id.* at 191 (noting that the United States' failure to reduce its MMR is inexcusable "when we consider the fact that . . . numerous developing countries, such as Vietnam . . . , with much fewer resources that the United States, are making strides towards meeting their goals of reducing preventable maternal deaths, while the United States is backsliding").

[191] *See id.* at 189.

[192] *See* Derrick A. Bell, Jr., Brown v. Board of Education *and the Interest-Convergence Dilemma*, 93 HARV. L. REV. 518, 524 (1980) [hereinafter Bell, *Interest-Convergence Dilemma*]; Derrick A. Bell, Jr., *Racial Remediation: An Historical Perspective on Current Conditions*, 52 NOTRE DAME L. REV. 5, 12 (1976) [hereinafter Bell, *Racial Remediation*] ("[I]t is highly unlikely that the white self-interest factors which so clearly motivated earlier, less significant civil rights breakthroughs were absent when the Brown decisions were formulated.").

[193] *See* Bell, *Racial Remediation*, *supra* note 192, at 12.

[194] *See generally* MARY L. DUDZIAK, COLD WAR CIVIL RIGHTS: RACE AND THE IMAGE OF AMERICAN DEMOCRACY 79–114 (2011).

[195] *See* Bell, *Racial Remediation*, *supra* note 192, at 12.

[196] *See* DUDZIAK, *supra* note 194, at 12–14.

foundly antidemocratic regime.[197] To be precise, Soviets brought attention to black people living in the Jim Crow South. Legal historian Michael Klarman gives the example of "Soviet foreign minister V. M. Molotov ask[ing] Secretary of State Jimmy Byrnes how Americans could justify pressing the Soviets to conduct free elections in Poland when America did not guarantee them in South Carolina or Georgia."[198]

Bell argues that the formal equality that black people achieved in the 1950s and 1960s was not the result of powerful white people having a change of heart in the face of the Civil Rights Movement.[199] Rather, it was the result of an interest convergence between subjugated black people and powerful white people.[200] As most black people wanted to dismantle the formal system of apartheid, many white people came to want an end to this system as well. However, while most black people desired the end of apartheid because they knew that it was incompatible with their dignity, humanity, and citizenship, many white people desired the end of apartheid because it was the only way that the United States could achieve ideological and political dominance in the international arena.[201]

Inasmuch as the high ratios of maternal mortality in the United States are a *racial* problem, the lesson of the Civil Rights Movement and the Cold War may be that we ought to be pessimistic that those with the power to effect change will do so because they simply will come to believe that it is a moral imperative.[202] The lesson of the Civil Rights Movement and the Cold War may be that the United States must come to see it as in its interest to rectify a racial injustice. The circumstances under which the United States would perceive racial disparities in maternal mortality as such are impossible to predict. It may be wise, however, for those interested in racial justice to continue to bring international attention to the racial tragedy unfolding within our borders.[203] When the circumstances develop that would make the

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197 *See id.* at 12 ("The Soviet Union capitalized on this weakness, using the race issue prominently in anti-American propaganda.").

198 MICHAEL J. KLARMAN, *BROWN V. BOARD OF EDUCATION* AND THE CIVIL RIGHTS MOVEMENT 30 (2007).

199 *See* Bell, *Interest-Convergence Dilemma*, *supra* note 192, at 524–26.

200 *See id.*

201 *See id.* at 524 (contending that the decision in *Brown* increased America's political credibility abroad).

202 This might be especially true if addressing or eliminating racial disparities in maternal mortality threatens white people's status—as was the case in dismantling Jim Crow.

203 Notably, international human rights bodies have already paid attention to racial disparities in maternal mortality in the United States. In 2014, the United Nations Committee on the Elimination of Racial Discrimination called on the United States to

United States interested in doing something about it, the international community will already be aware of it.

B. A Critique of the Solutions Proposed to Eliminate Racial Disparities in Maternal Mortality

There is a danger that an unsophisticated effort to eliminate racial disparities in maternal mortality will produce new forms of disenfranchisement. That is, there is a strong possibility that black women will suffer increased surveillance if policymakers design initiatives to lower MMR among black women without paying close attention to the fact that these initiatives will be implemented on a terrain that is rife with racism, sexism, and classism.

In earlier work, I have explored the intense surveillance to which governments subject poor pregnant women.[204] These works investigate how New York's Medicaid program compels Medicaid-reliant pregnant women in the state to disclose large amounts of highly intimate information upon their initiation of prenatal care.[205] Poor pregnant women are forced to confess the details of their diets; their histories with sexual violence, intimate violence, and substance use; any contact they have had with the criminal legal system or the child protective system; any bouts of homelessness that they have suffered; and other intimate facts about themselves.[206] The government's reasons for compelling these confessions are many.[207] On its face, the state is interested in protecting children and, as such, seeks to ensure that a pregnant woman is capable of competently parenting the child that she will birth.[208] Additionally, the state is aware that poverty exposes the poor to violence—in the form of food insecurity, housing insecurity, lack of access to healthcare, and interpersonal violence.

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make efforts to eliminate these disparities, as the failure to do so left the United States in violation of its human rights obligation to end racial discrimination in all forms. COMM. ON THE ELIMINATION OF RACIAL DISCRIMINATION, *Concluding Observations on the Combined Seventh to Ninth Periodic Reports of the United States of America*, U.N. Doc. CERD/C/USA/CO/7-9, at 7 (Sept. 25, 2014).

[204] BRIDGES, REPRODUCING RACE, *supra* note 109; Khiara M. Bridges, *Privacy Rights and Public Families*, 34 HARV. J.L. & GENDER 113 (2011).

[205] *See* Bridges, *supra* note 204, at 124–32.

[206] *See id.*

[207] *The Poverty of Privacy Rights* argues that the underlying reason for the state's requirement that poor pregnant women and poor mothers disclose intimate information about themselves is the moral construction of poverty and the presumption that people are poor because there is something wrong with them. KHIARA M. BRIDGES, THE POVERTY OF PRIVACY RIGHTS 37–64 (2017). As such, the surveillance of poor mothers is imperative, as their children are being cared for by people who, by definition, have something presumptively wrong with them. *Id.*

[208] *Id.* at 1–10.

Accordingly, the state seeks to protect poor women from these varieties of violence—at least during the period of their pregnancies.[209]

This is to say that the state's reasons for subjecting poor pregnant women to interrogation and regulation are not nefarious. Indeed, the state's intentions are golden. However, because poverty impacts, and damages, multiple aspects of a person's life—the psychological, the emotional, the physical—the state must intervene in multiple aspects of a person's life in order to address all of poverty's impacts. Accordingly, the interrogations and interventions to which the pregnant poor are subjected are wide-ranging and deep.[210]

Further complicating the matter is that the state's interventions into poor women's pregnancies occur within a social context of racial inequality, xenophobia, and classism. Thus, society tolerates excesses—when, for example, the state errs on the side of protecting children and wholly dismisses a woman's interest in keeping her private life private—because the women subjected to these interventions have been discursively maligned. The consequence is a system that, although designed with the best of intentions, is quite punitive and has pernicious effects on the ground.[211]

The concern is that something similar will develop in the context of racial disparities in maternal mortality. The best of intentions may motivate these efforts. However, because racism, like poverty,[212] impacts and damages multiple aspects of a person's life, the state will have to intervene in multiple aspects of a person's life in order to address all of racism's impacts.

As many observers have argued, the high frequency of pregnancy-related death that black women encounter is a product of racism.[213] Accordingly, in order to address black maternal mortality—

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[209] *Id.*

[210] THE POVERTY OF PRIVACY RIGHTS extends this analysis beyond pregnancy, arguing that poor mothers are surveilled as they try to raise their children within conditions of poverty. *Id.* at 101–32.

[211] *See* BRIDGES, REPRODUCING RACE, *supra* note 109 (discussing the harms that pregnant women reliant on Medicaid endure).

[212] It may be inaccurate to say that racism is "like poverty" because the analogy may suggest that racism and poverty are entirely distinct phenomena. In reality, racism may be inextricable from poverty. That is, the United States may allow poverty to persist—and it may support those social arrangements that produce poverty—because those who disproportionately bear the burdens of poverty are nonwhite. *See* BRIDGES, CRITICAL RACE THEORY, *supra* note 154, at 215–32. In like manner, poverty may be inextricable from racism to the extent that the impoverishment of disproportionate numbers of nonwhite people may give truth to the racist notion that nonwhite people are fundamentally different from white people.

[213] *See, e.g.*, Joia Crear-Perry, *Race Isn't a Risk Factor in Maternal Health. Racism Is.*, REWIRE.NEWS (Apr. 11, 2018), https://rewire.news/article/2018/04/11/maternal-health-replace-race-with-racism; *see also* Elizabeth Dawes Gay, *Serena Williams Could Insist that*

that is, in order to address a phenomenon that racism has wrought—the state may have to subject black women to wide-ranging, privacy- and dignity-denying interrogations and interventions in order to save their lives. In other words, *racism creates the risk that efforts to address the effects of racism will further marginalize and subordinate the victims of racism*. Moreover, because the women subjected to these efforts will be black, we should expect that, due to the marginalizing discourses that attach to black bodies, society will tolerate excesses and indignities. Consider the following proposals for addressing racial disparities in maternal mortality:

> [Because] Black women are more likely to have a delayed entry into prenatal care[, there is a] need for a comprehensive assessment of maternal health (beyond reproductive health) to occur both at the first prenatal visit, whenever that occurs, and at the six-week postpartum visit to ensure that appropriate referrals and interventions are offered to optimize the management of preexisting conditions and to ensure that pregnancy-associated conditions have resolved and are not merely late diagnoses of preexisting conditions.[214]

> The structured psychosocial risk screening interview . . . [that the author recommends] include[s] assessments for moderate/high risk of depression, lack of telephone access, food insecurity, housing instability, lack of social support, and transportation access, a strategy that may allow for real-time engagement with social determinants of health. *Screening for impact of psychosocial determinants of health may be most effective if systematically repeated throughout pregnancy*.[215]

> [P]opulation-level data [should be shared] with health care providers to improve their understanding of factors that contribute to health inequities. Providers can tailor interventions to the health care needs and risks inherent in the patient populations they serve.[216]

> [A]n active, systematic mental health and violence risk screening, during both antepartum and postpartum periods, should be prioritized for at-risk pregnancies.[217]

Doctors Listen to Her. Most Black Women Can't., THE NATION (Jan. 18, 2018), https://www.thenation.com/article/archive/serena-williams-could-insist-that-doctors-listen-to-her-most-black-women-cant.

214 Metcalfe et al., *supra* note 126, at 94.

215 Gadson et al., *supra* note 116, at 313 (emphasis added).

216 N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, SEVERE MATERNAL MORBIDITY IN NEW YORK CITY, 2008–2012, at 24 (2016).

217 LA. DEP'T OF HEALTH & HOSPS., LOUISIANA PREGNANCY-ASSOCIATED MORTALITY REVIEW, 2008, at 10 (2012). Questions remain about how populations will be identified as

It should be apparent that these efforts are extremely invasive. In threatening to strip the pregnant women of any privacy that she enjoys—before, during, and after pregnancy—they also threaten her dignity.

Nevertheless, it is difficult to describe these proposals as nefarious. They appear to be well-reasoned efforts to get at the root of the elevated MMR among black women. However, because the root of elevated MMR is in racism—in the fact that black women may be more likely to enter pregnancy with chronic conditions and comorbidities, may be more likely to live in physical environments that compromise their health, may be subjected to the chronic stress that results in the weathering of body systems, may be more likely to be poor, and may be more likely to find healthcare inaccessible—the efforts will have to be grand in scope. Indeed, racism itself has been grand in scope.

Moreover, because of the racist discourses that have attached to black women—about the hardiness of their bodies,[218] about their sexual profligacy,[219] about their fecundity,[220] about their undeserved sense of entitlement[221]—we should expect that society will tolerate the excesses of a system designed to intervene in the multiple causes of racial disparities in maternal mortality. We should expect that these excesses will be politically acceptable.[222]

In essence, the point is that if we do not think particularly highly of the women that we are trying to save—if they are the subjects of discourses that allow us to despise them—we will likely marginalize them in our attempts to save them.

In truth, we are "damned if we do, damned if we don't." We will injure black women if we try to save them. And we will injure black

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"at-risk." *See generally* BRIDGES, REPRODUCING RACE, *supra* note 109, at 144–200 (discussing how poverty influences which populations are labeled "at-risk").

218 *See* Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCI. U.S. 4296 (2016) (discussing a study documenting that black Americans are undertreated for pain).

219 *See* DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 10–12 (2d ed. 2017) (describing the United States' historical reliance on myths of black promiscuity).

220 *See id.* at 12 (referencing specifically the United States' myth of black hyperfertility and providing examples of this myth's perpetuation through literature and more scholarly treatments).

221 *See id.* at 17–19 (analyzing the origins and perpetuation of "The Welfare Queen" myth).

222 *See* Dorothy E. Roberts, Rust v. Sullivan *and the Control of Knowledge*, 61 GEO. WASH. L. REV. 587, 597 (1993) (discussing how the Court's decision in *Rust v. Sullivan*, which upheld regulations barring care providers from counseling an indigent clientele on abortion, was "politically acceptable" due to the race of those affected by the regulations).

women if we do not try to save them. But it is important to underscore that the paradox is created because racial injustice is so pernicious that even the efforts to address racial injustice will likely have pernicious effects.

C. A Critique of the Practice of Blaming Women for Dying

A common theory as to why the United States has a higher MMR than other industrialized nations—and, specifically, as to why the frequency of maternal death has increased in more recent years—is that the health of the population of women of reproductive age in the United States has worsened.[223] Specifically, researchers have posited that more women are obese when they become pregnant; further, more women are entering pregnancy with chronic conditions—namely, hypertension, diabetes, and heart disease.[224] Additionally, many researchers have observed that women are delaying pregnancy and, therefore, are older when they attempt pregnancy.[225] Hypertension, diabetes, heart disease, obesity, and advanced maternal age are all risk factors for pregnancy complications.[226] According to this theory, if the MMR in the United States is ticking upwards, then it is an expected consequence of women not being as healthy when they

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[223] *See* Metcalfe et al., *supra* note 126, at 92–93 (stating that in recent years, women are "more likely to enter pregnancy with a preexisting chronic disease," observing that "[m]aternal health status before pregnancy is an important contributor to obstetric outcomes," and asserting that the incidence of severe maternal morbidity may be decreased if "women enter[ ] pregnancy in a healthier state").

[224] *See* Creanga, *Maternal Mortality*, *supra* note 2, at 299 ("Studies have shown that an increasing number of pregnant women in the United States have chronic health conditions such as hypertension, diabetes, and chronic heart disease, and presence of such conditions do indeed put a pregnant woman at a higher risk of pregnancy complications."); Nelson et al., *supra* note 91, at 1007 ("[I]ndividual-level factors may explain worsening U.S. obstetric outcomes over the last two decades, such as . . . increased prevalence of obesity and other chronic health conditions . . . .").

[225] *See* Nelson et al., *supra* note 91, at 1007 (stating that the worsening of obstetric outcomes in the United States may be attributed to "temporal trends in the number of births to women of advanced maternal age"); Andreea A. Creanga, Cynthia J. Berg, Carla Syverson, Kristi Seed, F. Carol Bruce & William M. Callaghan, *Pregnancy-Related Mortality in the United States, 2006–2010*, 125 OBSTETRICS & GYNECOLOGY 5, 9–10 (2015) [hereinafter Creanga et al., *Pregnancy-Related Mortality, 2006–2010*] ("U.S. women have been delaying childbearing, and although less than 15% of live births are to women 35 years of age or older, 27.4% of pregnancy-related deaths were among this age group . . . ."); *see also* Creanga, *Maternal Mortality*, *supra* note 2, at 300 (noting that "[i]n vitro fertilization techniques permit older women, some with chronic medical conditions, to become pregnant," and as a result, "[n]ot surprisingly, causes of pregnancy-related death have changed over time").

[226] *See* Creanga, *Maternal Mortality*, *supra* note 2, at 299; Nelson et al., *supra* note 91, at 1012 ("Maternal obesity . . . has been consistently reported to increase the risk of pregnancy complications, including thromboembolic disease, gestational diabetes mellitus, and hypertensive disorders of pregnancy.").

become pregnant as they were in decades past.[227] Further, if black women are dying more frequently than other groups of women, then it is simply because black women are not as healthy when they become pregnant as their non-black counterparts.[228]

We ought to be sensitive to how this narrative about the causes of racial disparities in maternal mortality can function to blame black women for dying or nearly dying when they attempt motherhood. This narrative can have the effect of placing responsibility for maternal deaths on the women dying from pregnancy-related causes. When black women die from pregnancy complications that have some relationship to obesity, diabetes, heart disease, and hypertension, the sense may be that black women did it to themselves.[229] They let themselves go. They gorged themselves on unhealthy foods. They did not exercise. They did not take care of themselves. If they die when they

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[227] *See* LYN KIELTYKA, POOJA MEHTA, KARIS SCHOELLMANN & CHLOE LAKE, LA. DEP'T OF HEALTH, LOUISIANA MATERNAL MORTALITY REVIEW REPORT, 2011–2016, at 13 (2018) (noting that "increased chronic disease burden and increasing maternal age may be contributing factors" to the increase in pregnancy-related deaths); Nelson et al., *supra* note 91, at 1011 (noting a study that showed that thirty-one percent of the increase in maternal deaths "was attributable to the proportion of obese women of childbearing age" and that seventeen percent of the increase was due to the "proportion of births to women with diabetes"); Creanga et al., *Pregnancy-Related Mortality, 2006-2010*, *supra* note 225, at 10 ("Studies show that an increasing number of pregnant women in the United States have chronic health conditions such as hypertension, diabetes, chronic heart disease, and obesity, [and] these conditions put pregnant women at risk of adverse outcomes." (citations omitted)); REPRODUCTIVE INJUSTICE, *supra* note 34, at 13 (noting that the "Centers for Disease Control and Prevention (CDC) points to an increase in pregnant women with chronic health conditions as a driving factor for the rise in maternal mortality between 2006 and 2009"); *see also* Young, *Hospitals Know How to Protect Mothers*, *supra* note 6 ("For decades, hospitals and medical experts have often blamed rising maternal deaths and injuries on women for being unhealthy or overweight, or pointed to risk factors such as poverty or the age of mother."); Martin, *supra* note 22 ("[M]any researchers and clinicians have formed a distorted picture of why mothers die, often putting the blame unfairly on women themselves . . . .").

[228] *See, e.g.*, Bryant et al., *supra* note 115, at 339 ("Racial/ethnic minorities are at increased risk of pregnancy overweight and obesity, and these conditions are associated with an ever-growing list of pregnancy complications . . . ."); N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, *supra* note 216, at 6 (2016) ("There are likely many contributors to these [racial] disparities, *including pre-conception health status, prevalence of obesity and other co-morbidities* and access to care.") (emphasis added)); REPRODUCTIVE INJUSTICE, *supra* note 34, at 13 ("Compared to white women, women of color fare significantly worse in key general health indicators including diabetes, obesity, heart disease, and hypertension. These poor health indicators are often exacerbated during pregnancy, especially if they remain untreated, and are a driving force behind preventable maternal deaths."). Of note, one rarely sees the claim that racial disparities in maternal mortality can be attributed to black women being older than white women when they become pregnant.

[229] *See* YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 16 (noting that "the increased prevalence of [certain chronic conditions, like hypertension, diabetes, and obesity] is often used to shift the responsibility of poor maternal outcomes to women for so-called personal 'lifestyle' decisions").

become pregnant, the story concludes, then they have only themselves to blame.[230]

This narrative might be redeemed if it works to place within view the structural forces that have led black women to suffer from chronic conditions at higher rates.[231] If the narrative causes observers to consider the social contexts within which black women live their lives, then observers may see that women are not freely making choices that lead them to become obese and/or develop other chronic conditions. For example, it is inordinately difficult to maintain a healthy diet when healthy foods are not affordable or when they are physically inaccessible. It is quite challenging to exercise regularly when work and caretaking consumes one's days. That is, there are *structural* reasons for the disproportionate rates at which black women suffer from hypertension, diabetes, heart disease, and obesity.[232] The fact of the "preexisting condition"—when it is not subjected to critical analysis—may work to lay blame at black women's feet while simultaneously removing attention from the social arrangements that have made black women sicker than their white counterparts. If the fact of the "preexisting condition" is not set within its structural context, it may function to absolve society of responsibility for the poor states of health that black women disproportionately inhabit.

Importantly, there is strong evidence against the claim that disproportionate rates of chronic conditions among black women fully

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230 A series on maternal mortality in the United States published by *USA Today* identified a disturbing number of instances in which pregnant women have been blamed for the United States' high MMR. It notes that many state MMRCs have chosen to emphasize "lifestyle choices and societal ills"—like intimate violence and the opioid epidemic—in their analyses of maternal deaths. Ungar, *supra* note 185. The article reports that Representative Mike Moon "said during . . . debate on the House floor that women smoking, being overweight and not going to the doctor while pregnant" explains the high incidence of maternal mortality in the United States. *Id.* The same series also reports that officials of a hospital in Utah where one out of every nine patients suffered a hemorrhage "were quick to blame the women as being unusually high risk." Young, *Hospitals Know How to Protect Mothers*, *supra* note 6.

231 Moreover, if advanced maternal age is a risk factor for pregnancy complications, then we ought to pay attention to the structural reasons for women's choice to delay childbearing. How have we structured the labor force such that women think it advisable to wait until they are more established in their careers before having children? How has the economy transformed such that it is unadvisable for women and their partners to create families when they are younger?

232 Bryant et al., *supra* note 115, at 339 (observing that obesity among women of color may be attributable to "physical and built environments [that] are not conducive to exercise" and that "are often more prevalent among minority populations"); YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 17 (stating that "[l]ifestyle decisions . . . are influenced by context-dependent socioeconomic, cultural, and political environments, which in turn are shaped by policy-level decisions" and asserting that "risk factors, such as obesity and diabetes," need to be contextualized within "structures and systems").

explain racial disparities in maternal mortality. Many studies have documented that even if one controls for the increased prevalence of preexisting conditions among black women, black women *still* have a greater chance of dying from a pregnancy complication than their white counterparts.[233] We ought to interrogate why the narrative that black women are dying because they are unhealthy has been as believable as it has been to so many observers.

Moreover, it seems clear that the frequency of maternal death and near-death need not increase simply because there is an increase in prevalence of chronic conditions among the population of women of reproductive age. There have been increases in the incidence of hypertension, diabetes, and obesity in other industrialized nations; however, the MMR in those nations has not increased.[234] In fact, it has decreased.[235] This demonstrates that having a chronic condition when one enters pregnancy need not be a death sentence.[236] If we wanted to make pregnancy and childbirth survivable for women with these conditions, we could.

Substance use during pregnancy provides a revealing context for exploring the phenomenon of faulting women for dying. Substance use disorders have played a significant role in maternal mortality and morbidity. For example, New York City's MMRC calculated that between 2006 and 2010, 18.2% of fatal injuries associated with preg-

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233 *See* Bingham et al., *supra* note 35, at 190 ("[C]ontrary to common assumptions, the racial and ethnic disparities in outcomes are not always due to women of color having a higher prevalence of diseases. . . . [W]omen of color often are less likely to receive beneficial treatments that could have prevented their death or injury."); Goffman et al., *supra* note 103, at 600 (stating the results of an analysis that showed that racial disparities in maternal morbidity and mortality "could not be explained by other risk factors that were found to be significantly associated with adverse outcome in univariable analysis," including "age, obesity, history of a chronic medical condition, prior cesarean delivery and gravidity"). *See also* BOYD ET AL., *supra* note 84, at 5 (noting that while New York City's "Black population" is disproportionately affected by "obesity" and "underlying chronic illness," a "causal relationship" between these conditions and the increased risk of maternal mortality for black women has not been established); Moaddab et al., *supra* note 40, at 710 ("Although medical factors such as hypertensive disease, tobacco use, and obesity have been shown to be correlated with increased maternal morbidity, statewide population differences in rates of these conditions were not significantly correlated with mortality ratios.").

234 *See* YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 5 ("In the past two decades, the percentage of maternal deaths attributable to chronic conditions such as hypertension and diabetes has risen sharply in the U.S.; however, globally no parallel rise in maternal deaths has been seen alongside increasing rates of obesity and other risk factors.").

235 *See id.*

236 *See* Young, *Hospitals Know How to Protect Mothers*, *supra* note 6 (quoting the medical director of the California Maternal Quality Care Collaborative as saying "[j]ust because you're older and heavier, doesn't mean you should die," and "[t]hat just means [the healthcare provider] should be on guard, you should bring your A game").

nancy were due to "substance abuse."[237] The MMRC in Louisiana determined that "substance abuse" was present in 26% of pregnancy-associated deaths in the state.[238] And the MMRC in Missouri concluded that "maternal deaths due [to] drug overdose" were "a significant public health concern."[239]

If substance use during pregnancy has contributed to maternal deaths and near misses—which it undoubtedly has[240]—then it is reasonable to conclude that some of these cases of mortality and morbidity might have been avoided if a provider knew about and managed a pregnant woman's substance misuse or dependency. A provider might direct her towards a drug treatment facility. If she has an opioid dependency, a provider might provide her medication-assisted treatment (MAT) so as to stabilize her and avoid the risk that she might overdose.[241] Consequently, in order to reduce the number of maternal deaths or near-misses that substance use causes or to which substance use contributes, policymakers may think it advisable to screen all women for substance use, misuse, and dependency. And this is precisely what some experts have recommended. For example, a report issued by nine MMRCs suggests that if a review of a maternal death reveals that "a lack of provider assessment" of substance use contributed to the death, then "an actionable recommendation could be that prenatal care providers should screen all patients for substance use disorders at their first prenatal visit."[242] Another commission concluded in 2008 that "[g]iven the prevalence of substance abuse as a clinical risk indicator, the development of enhanced resources for behavioral health/substance abuse screening during preconception, antenatal and birth/postpartum time periods needs to be emphasized."[243] The same commission arrived at a similar conclusion six years later, recommending that the state "[o]ffer universal substance use screening . . . during pregnancy."[244]

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237 BOYD ET AL., *supra* note 84, at 17.

238 LA. DEP'T OF HEALTH & HOSPS., *supra* note 217, at 9.

239 VENKATA PS GARIKAPATY, MO. DEP'T OF HEALTH & SENIOR SERVS., PREGNANCY ASSOCIATED MATERNAL MORTALITY REVIEW (PAMR) IN MISSOURI (2015), https://nurturekc.org/wp-content/uploads/2015/01/Missouri-Maternal-Mortality-System.pdf.

240 *See, e.g.*, Gadson et al., *supra* note 116, at 309 ("Substance use disorders in particular may coincide with medical and social vulnerabilities to increase risk of maternal death.").

241 *See* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, ACOG COMM. OPINION NO. 711: OPIOID USE AND OPIOID USE DISORDER IN PREGNANCY 6 (Aug. 2017) (documenting that medication-assisted treatment remains the gold-standard treatment for opioid dependency during pregnancy).

242 REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 29.

243 LA. DEP'T OF HEALTH & HOSPS., *supra* note 217, at 11.

244 KIELTYKA ET AL., *supra* note 227, at 28.

These proposals, as motivated by good intentions as they may be, will have disastrous consequences if implemented within a context wherein it is politically acceptable, and desirable, to punish pregnant women for their substance use. Essentially, a well-intentioned policy that endeavors to save women's lives could result in substance-using and -dependent women being funneled into the criminal legal system.[245]

We have already seen government's response to substance use during pregnancy. During the crack cocaine crisis of the 1980s—when the pregnant women who were struggling with cocaine dependencies were disproportionately black—the state responded with arrest, prosecution, and incarceration.[246] States charged and convicted women who had used cocaine during their pregnancies with crimes ranging from child maltreatment, assault, and, in cases where there was a fetal death, homicide.[247]

In the face of the opioid epidemic, many states continue to respond to substance use during pregnancy with the criminal law.[248] Tennessee passed the first law that was designed to criminalize substance use during pregnancy—a law that legislators allowed to expire after advocates in the state mounted a campaign to achieve that result.[249] Prosecutors in Alabama have been using a law that was intended to punish individuals who manufacture crystal methamphetamine in the presence of children—thereby exposing the children to the risk of an explosion injuring or killing them—to prosecute women who use controlled substances while pregnant.[250] And

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[245] Pregnant women who use substances might be funneled into the criminal legal system unless there is a concerted effort to prevent that very result. With this in mind, while the Louisiana MMRC recommends screening pregnant women for substance use disorders, it is careful to note that the response to a positive drug screen should not be punitive. It specifically recommends that the state should "[m]aintain linkages to evidence-based decriminalized medication assisted therapy for opioid use disorder" in pregnant women. *Id.*

[246] Khiara M. Bridges, *Race, Pregnancy, and the Opioid Epidemic: White Privilege and the Criminalization of Opioid Use During Pregnancy*, 133 HARV. L. REV. 770, 775 (2020); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1420–21 (1991).

[247] *See* Bridges, *supra* note 246, at 807.

[248] *See id.* at 776.

[249] *See* TENN. CODE ANN. § 39-13-107(c)(2) (2014); Blake Farmer, *Tennessee Lawmakers Discontinue Controversial Fetal Assault Law*, NPR (Mar. 23, 2016 4:24 PM), https://www.npr.org/2016/03/23/471622159/tennessee-lawmakers-discontinue-controversial-fetal-assault-law.

[250] *See* ALA. CODE § 26-15-3.2 (2006); Grace Howard, *The Limits of Pure White: Raced Reproduction in the "Methamphetamine Crisis"*, 35 WOMEN'S RTS. L. REP. 373, 374 (2014) (describing how Alabama's law has been used to arrest "pregnant women on charges ranging from chemical child endangerment to manslaughter for their behaviors during pregnancy, primarily for alleged illegal substance use").

prosecutions for substance use during pregnancy continue at a steady pace in South Carolina—the state where one woman who used cocaine while pregnant spent eight years in jail after being convicted for murder subsequent to the birth of her stillborn baby.[251]

Inasmuch as it has been politically acceptable for the state to respond punitively to pregnant women with substance use disorders when they are believed to harm their fetuses, we might not be optimistic that society will have much sympathy if pregnant women who use controlled substances harm *themselves*. If a pregnant woman's death or near-miss pregnancy complication can be traced to a substance that she intentionally ingested, we should expect that many in society would find it easy, and morally acceptable, to blame her for injuring or killing herself. Again, if we do not think particularly highly of the women that we are trying to save, we run a significant risk of marginalizing them in our attempts to save them.

Commentators have critiqued the willingness of some analysts to blame women for dying or nearly dying during their pregnancies. In its "Deadly Deliveries" series on maternal mortality in the United States, *USA Today* observed the tendency to fault women for dying from pregnancy-related causes, and it sought to shift responsibility towards the physicians and nurses that provide healthcare to pregnant women and the hospitals where women receive this care. The series observed that inquiries into maternal mortality very rarely focus on the quality of the care that women receive,[252] and it criticized the Preventing Maternal Deaths Act for failing to require that the MMRCs it funds pay attention to the quality of the care that women are being given.[253] The series endeavored to bring attention to the possibility that provider negligence and inferior care likely bear some

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[251] Press Release, Drug Policy All., South Carolina Supreme Court Reverses 20-Year Homicide Conviction of Regina McKnight (May 11, 2008), https://www.drugpolicy.org/news/2008/05/south-carolina-supreme-court-reverses-20-year-homicide-conviction-regina-mcknight. The court that convicted the woman disregarded medical evidence that the stillbirth was caused by an infection, as well as studies showing no link between cocaine use and heightened risk for stillbirths. Jeanne Flavin & Lynn M. Paltrow, *Punishing Pregnant Drug-Using Women: Defying Law, Medicine, and Common Sense*, 29 J. ADDICTIVE DISEASES 231, 235 (2010).

[252] *See* Ungar, *supra* note 185 ("Fewer than 20 states that have panels studying mothers' deaths identify medical care flaws such as delayed diagnoses, inadequate treatments or the failures of hospitals to follow basic safety measures. . . . Among 10 states with the highest death rates, just four panels reported on flaws in medical care."); Young, *Mothers Are Dying*, *supra* note 63 (noting that many "state maternal death review committees across the country often avoid scrutinizing medical care that occurred in the days and hours before mothers' deaths").

[253] *See* Young, *Mothers Are Dying*, *supra* note 63 (criticizing the fact that the Preventing Maternal Deaths Act "does not specifically require states to examine whether flawed medical care played a role" in a pregnancy-related death).

significant responsibility for the comparatively high rates of maternal mortality in the United States.

While *USA Today*'s intervention is an important one inasmuch as it acknowledges the unfairness and cruelty of holding the dead responsible for dying, it is important that the search for the causes of maternal mortality—and racial disparities in maternal mortality, specifically—does not simply become a search for the "real" bad actor. Those who assert that women are to blame for dying during pregnancy because they have given themselves obesity, diabetes, hypertension, or heart disease err because, in addition to ignoring the social constraints within which women live, they individualize the problem. The problem becomes individual women and the poor lifestyle choices that they have made. However, those, like *USA Today*, who seek to shift the focus to bad providers and bad hospitals make a similar error: They also individualize the problem. The difference is simply that those in the latter camp identify different individual bad actors: careless physicians and nurses and negligent hospitals.

Certainly, some number of maternal deaths might be due to medical negligence. However, systemic and structural factors—like "weathering," our two-tiered healthcare system, residential segregation and the concentration of health-damaging factors in neighborhoods of color, the closure of obstetric units in public hospitals, the racist discourses that attach to pregnant bodies of color—likely bear a greater share of the responsibility for the indefensibly high MMR among black women in the United States. In essence, it is important that we are not myopic in our identification of the causes of maternal mortality in the United States. Searching for the blameworthy actor—both when the actor is identified as the woman who dies during pregnancy, or the physician who delivers substandard care—simplifies an exceedingly complex issue whose roots are in the structures that arrange our society.[254] The solutions that society pursues when it

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[254] *See* Laura Katzive, *Maternal Mortality and Human Rights*, 104 AM. SOC. INT'L L. PROC. 383, 385 (2010) ("In some settings, a preventable maternal death may look like a case of provider malpractice. The task . . . is to show that responsibility lies beyond a single provider and can be attributed to a health system failure."); Wilson, *supra* note 128, at 239 (criticizing when a problem of maternal mortality and the solutions proposed to it are "restricted to individual behaviors or interactions between doctors and patients" and advocating that attention be paid to "[c]ity policy action, or lack thereof"); Yamin, *supra* note 42, at 96–97 (noting that pursuing "effective accountability" in the arena of maternal deaths "requires moving beyond . . . punishing individual perpetrators" and towards advocating for the promotion of "systemic and institutional changes that create conditions under which women can enjoy their rights to maternal health, and not just [the punishment of] identified lapses in performance").

believes that individual bad actors are the cause of a problem will hardly be effective or satisfactory.

In this Part, we have seen that racism inflicts a multifaceted injury on black women: 1) racism is a structural determinant of poor health, 2) racism produces a moralizing/punitive discourse about those who suffer from poor health, and 3) racism limits efforts to address poor health outcomes. In light of the layered nature of the harm that racism perpetrates, there should be little wonder that the black maternal death rate is as elevated as it is.

The next Part elaborates on the claim that racism limits efforts to address poor health outcomes. Specifically, it describes Congress's recent foray into addressing the United States' relatively high MMR: the Preventing Maternal Deaths Act. Widely hailed as an important first step in lowering the country's MMR, the Act, nevertheless, is woefully inadequate—and potentially dangerous.

III
THE PREVENTING MATERNAL DEATHS ACT

On December 21, 2018, the president signed the Preventing Maternal Deaths Act into law.[255] The law, which many observers believe is a direct result of the attention that the media recently have given to the United States' comparatively high MMR,[256] allocates twelve million dollars annually for five years to the issue.[257] The sixty million dollars that the government has devoted to reducing the frequency of maternal mortality is more than the Act's supporters had imagined Congress would allot to addressing the problem.[258]

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[255] Katy Backes Kozhimannil, Elaine Hernandez, Dara D. Mendez & Theresa Chapple-McGruder, *Beyond The Preventing Maternal Deaths Act: Implementation and Further Policy Change*, HEALTH AFFAIRS BLOG (Feb. 4, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190130.914004/full. The avowed purposes of the law are to "support States in their work to save and sustain the health of mothers during pregnancy, childbirth, and in the postpartum period, to eliminate disparities in maternal health outcomes for pregnancy-related and pregnancy-associated deaths, [and] to identify solutions to improve health care quality and health outcomes for mothers . . . ." Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, 132 Stat. 5047 (2018).

[256] *See* 162 CONG. REC. H10,060 (2018) ("The media's attention to the issue of maternal morbidity and mortality has shed light on serious problems within our healthcare system in terms of pre- and postpartum care and complications in the delivery room.").

[257] *See* Jones, *supra* note 19.

[258] *See* Elizabeth Chuck, *"An amazing first step": Advocates Hail Congress's Maternal Mortality Prevention Bill*, NBC NEWS (Dec. 19, 2018, 2:38 AM), https://www.nbcnews.com/news/us-news/amazing-first-step-advocates-hail-congress-s-maternal-mortality-prevention-n948951 (discussing advocates' hope in the bill's success).

Notably, support for the law was bipartisan.[259] Indeed, it unanimously passed both houses of Congress.[260] Historically speaking, perceptions that the issue of maternal mortality was a "Democratic" cause hampered efforts to tackle the issue.[261] In the past, Republicans failed to support proposed laws that endeavored to address the problem.[262] The Preventing Maternal Deaths Act represented a dramatic departure from this history inasmuch as the lead sponsor of the bill, Representative Jaime Herrera Beutler, is a "staunchly anti-abortion" Republican.[263] The success of the Preventing Maternal Deaths Act is owed to its failure to be identified with either party, allowing it to escape the perils of partisan politics. The next Part returns to a discussion of this aspect of the Act.

The primary aim of the law is to improve the quality of the information that exists about maternal mortality. Many have argued that the United States' comparatively high MMR is attributable to the poor quality of the data that is currently available about maternal deaths.[264] Understanding why people have made this argument requires some background on the present state of data-gathering about maternal mortality.

At present, there are two systems on the national level that collect information about maternal mortality, both of which are housed in the Centers for Disease Control and Prevention (CDC). The

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[259] *See* Martin, *supra* note 22 (noting that both Democrats and Republicans introduced the House and Senate bills into their respective houses of Congress).

[260] *Id.*

[261] *Id.* ("Members of Congress have introduced other bills in recent years . . . [but] the legislation was usually associated with one political party, Democrats. The bills did not gain traction.").

[262] *See id.*

[263] *See* Leslie Larson, *Republican Rep. Jaime Herrera Beutler Celebrates 'Miracle' Baby Girl Born with Potter's Sequence*, N.Y. DAILY NEWS (July 29, 2013), https://www.nydailynews.com/news/politics/republican-rep-jaime-herrera-beutler-celebrates-miracle-baby-girl-born-potter-sequence-article-1.1411714.

[264] *See Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S., Hearing Before the Subcomm. on Health of the Comm. on Energy & Commerce*, 115th Cong. 10 (2018) [hereinafter *Hearing on H.R. 1318*] (statement of Rep. Jaime Herrera Beutler) ("[T]he truth is that the available data is woefully inadequate, which greatly hinders our ability to understand why mothers are dying."); *Hearing on H.R. 1318*, at 49 statement of Stacey D. Stewart, President, March of Dimes) ("Our nation cannot prevent maternal mortality if we lack data about where and why it takes place."); AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 87 (stating that a "lack of comprehensive data collection and effective systems to analyze the data is contributing to the failure to improve maternal health" and that the absence of good data "is masking the full extent of maternal mortality and morbidity in the USA and is hampering efforts to analyze and address the problems and so improve maternal health overall"); Martin, *supra* note 22 (describing the "shortage of reliable data about what kills American mothers" as "one of the most fundamental problems underlying the maternal mortality crisis in the United States").

National Center for Health Statistics (NCHS) administers the first system, which uses information found on death certificates to identify deaths from pregnancy-related causes that occur during a woman's pregnancy, during childbirth, or up to forty-two days postpartum.[265] Epidemiologists can usually identify pregnancy-related deaths by examining death certificates because states have included a "pregnancy checkbox" on their death certificates that allows a physician, coroner, or medical examiner to indicate that the deceased was recently pregnant.[266] The other system is the Pregnancy Mortality Surveillance System (PMSS), which is the product of a collaboration between several state health departments and the Maternal Mortality Special Interest Group of the American College of Obstetricians and Gynecologists.[267] Like NCHS's program, PMSS uses death certificates and the "pregnancy checkbox" to identify pregnancy-related deaths.[268] Unlike NCHS's program, however, PMSS also identifies cases of maternal deaths through birth certificates or fetal death certificates that have been linked to a woman's death certificate.[269] Additionally, PMSS considers a maternal death to be one that occurs *up to a year* postpartum.[270]

Most experts have concluded that NCHS and PMSS are incapable of producing the data that the nation needs to reduce the frequency of maternal deaths.[271] This is because the NCHS and PMSS

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[265] REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 9.

[266] *Id.* at 10. Although the "pregnancy checkbox" allows for the identification of more pregnancy-related deaths than would be identified if the checkbox were not included on death certificates, a significant number of pregnancy-related deaths likely are still missed. Observers say that researchers would catch more of these deaths if they could link death certificates to birth certificates and/or fetal death certificates. *See* BLACK MAMAS MATTER, *supra* note 40, at 58–59 ("Studies have found that pregnancy-related deaths are substantially underestimated when cases are identified through death certificates alone, and that linking records lowers the number of missed cases."). Notably, this is the method for identifying cases of maternal mortality that the Pregnancy Mortality Surveillance System has adopted. *See* REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 9–10.

[267] Creanga, *Maternal Mortality*, *supra* note 2, at 297.

[268] *See* REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 9.

[269] *See id.* Some maternal deaths may come to the attention of PMSS through media searches. *See* Creanga, *Maternal Mortality*, *supra* note 2, at 297 (stating that information on maternal deaths occasionally comes to PMSS through "computerized media searches using key terms in Lexis Nexis").

[270] *See* REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 9.

[271] *See* Trude A. Bennett & Melissa M. Adams, *Safe Motherhood in the United States: Challenges for Surveillance*, 6 MATERNAL & CHILD HEALTH J. 221, 225 (2002) ("Surveillance can provide the basis for the research and public health actions that are needed for improvement, but current surveillance methods are inadequate.").

must rely on the limited information contained in a death certificate in order to attempt to understand why an individual death occurred. Death certificates communicate the reasons for a death through the International Classification of Diseases (ICD) codes, which allow a physician, coroner, or medical examiner to identify what she believes to be the cause of an individual's death.[272] However, the ICD codes lack "diagnostic nuance."[273] Further, they do "not communicate the interconnected stressors and system failures, often community-specific, that contributed to a particular maternal death."[274] The incomplete nature of the data that NCHS and PMSS receive limits the quality of the review that these bodies can conduct. As a result, these national-level surveillance systems can only identify disparities and trends; they are incapable of answering the more difficult question of *why* women are dying and what could be done to prevent these deaths.[275]

Further, the existing national-level surveillance systems likely miss many cases of maternal mortality.[276] While the introduction of the "pregnancy checkbox" undeniably allows NCHS and PMSS to identify more maternal deaths, the fact that both surveillance systems operate at the national level—as opposed to a state or local level—increases the likelihood that they will overlook some pregnancy-related deaths. If effective surveillance is to take place at a national level, it would be through a system that could compel states to provide detailed information about every maternal death and that analyzes the

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[272] *See* Donna L. Hoyert, Sayeedha F.G. Uddin & Arialdi M. Miniño, *Evaluation of the Pregnancy Status Checkbox on the Identification of Maternal Deaths*, 69 NAT'L VITAL STAT. REP. 1, 15 (2020). The pregnancy-related causes of death that can be identified through ICD codes are "hemorrhage, infection/sepsis, amniotic fluid embolism, thrombotic pulmonary or other embolism, hypertensive disorders of pregnancy, anesthesia complications, cerebrovascular accidents, cardiomyopathy, cardiovascular disease, and noncardiovascular medical conditions." Creanga, *Maternal Mortality*, *supra* note 2, at 297.

[273] YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 56.

[274] *Id.*

[275] *See* REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 55 (identifying state- and local-level MMRCs as the "gold standard" for review and prevention).

[276] The problem of missing maternal deaths was even more pronounced prior to the advent of the "pregnancy checkbox" on death certificates. One study estimates that while the checkbox allows for the identification of ninety-eight percent of all maternal deaths, researchers identified only sixty-two percent of such deaths before the introduction of the checkbox. *See* Hirshberg & Srinivas, *supra* note 91, at 333. Another study concludes that some thirty percent of pregnancy-related deaths would go uncounted without the checkbox. *See id.*

data with an eye towards identifying interventions that could prevent future deaths.[277] Such a system does not exist in the United States.[278]

Even if the government created a national system with these elements, most experts agree that it simply would not be as good as state-level efforts to compile and analyze data about pregnancy-related deaths. The assumption is that local bodies are in a much better position than a national body to generate a nuanced, contextual understanding of a maternal death and, as such, are better able to identify the interventions that need to be made to prevent similar maternal deaths from happening in the future. These local bodies are state MMRCs.[279]

MMRCs, which experts have described as the "gold standard" for analyzing maternal deaths,[280] consist of a multidisciplinary group of professionals with expertise that relates to maternal health: obstetricians, nurse practitioners, midwives, doulas, hospital administrators, epidemiologists, mental health experts, community members, and

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[277] *See* BLACK MAMAS MATTER, *supra* note 40, at 27 ("[T]here is no nationwide standard or system to compel, collect, and analyze high-quality, comprehensive data on maternal deaths and complications.").

[278] A national program for reviewing individual cases of maternal mortality exists in the UK. *See* Ozimek & Kilpatrick, *supra* note 28, at 181. This program, called Confidential Enquiries into Maternal Deaths, has been quite successful at reducing maternal deaths—despite the fact that it operates on a national level. *See* Kate Womersley, *Why Giving Birth Is Safer in Britain Than in the U.S.*, PROPUBLICA (Aug. 31, 2017), https://www.propublica.org/article/why-giving-birth-is-safer-in-britain-than-in-the-u-s (commenting on the success of the UK's approach). The efficacy of the program may be tied to the fact that the UK, unlike the United States, has a nationalized, single-payer healthcare system. Experts caution that the success of a similar system in the United States could be hampered if it does not address other "non-medical determinants" of health outcomes, like race and income. *See* JOHN BAUER, C. HICKS & R. CASSELMAN, WASH. STATE INST. FOR PUB. POLICY, SINGLE-PAYER AND UNIVERSAL COVERAGE HEALTH SYSTEMS: FINAL REPORT 6, 12, 38 (2019) ("Adopting a single-payer or universal coverage system of health care without addressing underlying risk factors may not allow the US to achieve the health outcomes attained in other high-income countries."). The Confidential Enquiries into Maternal Deaths program requires hospitals and providers to report all maternal deaths to a central database. *See* Ozimek & Kilpatrick, *supra* note 28, at 181. After the program administrators obtain full medical records, a pathologist and obstetrician confirm a cause of death. *See id.* A multidisciplinary committee of experts then reviews the care that the woman received. *See id.* A separate committee writes a report that highlights themes that emerged from analysis of the case. *See id.* If experts believe that it is possible to make effective interventions in light of the case, they design them with the committee's report in mind. *See id.*

[279] *See* REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 6 (stating that state and local MMRCs "are best positioned to comprehensively assess maternal deaths and identify opportunities for prevention"); YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 13 ("[State] MMRCs can carry out on-the-ground inquiries on incidences of maternal death, develop case-level context-specific narratives in addition to raw data, and help create policies that respond to state-specific needs.").

[280] *See* Creanga, *Maternal Mortality*, *supra* note 2, at 297.

mothers.[281] The committee conducts an in-depth investigation into every maternal death. The point of the investigation is to look beyond the clinical factors that may have led to the death—although these clinical factors remain an important part of the inquiry.[282] The MMRC's focus is supposed to be broader—analyzing the healthcare system that dispensed the care, the quality of the hospital that provided the care, the accessibility of providers to the pregnant woman, and the social context in which a woman lived.[283] At the end of the investigation, the answer to the question of why a woman died should go beyond an answer of "she suffered from cardiomyopathy" or "she developed sepsis." Instead, the MMRC ideally has put itself in a position to identify as factors in a death phenomena that exceed the strictly medical—like the distribution of hospital facilities in an area, poor communication within a hospital or between hospitals, a hospital's failure to implement policies or practices regarding treatment regimens for women presenting with certain symptoms,[284] or the premature termination of postpartum care at eight weeks after birth. In this way, after analyzing a pregnancy-related death, MMRCs should

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[281] *Hearing on H.R. 1318*, *supra* note 264, at 64 (statement of Joia Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative).

[282] *See* Cynthia S. Shellhaas, Julia Zaharatos, Linda Clayton & Afshan B. Hameed, *Examination of a Death Due to Cardiomyopathy by a Maternal Mortality Review Committee*, 221 AM. J. OBSTETRICS & GYNECOLOGY 1, 1 (2019) (stressing the urgency of "[d]ocumenting both clinical and nonclinical contributors to maternal death").

[283] *See* U.N. High Comm'r for Human Rights, *Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality*, U.N. Doc. A/HRC/21/22, at 17 (July 2, 2012) ("[R]eviews of all maternal deaths should be conducted routinely in order that lessons may be learned at all levels of the health system: from individuals' behaviour and practices to national policies, and along the continuum of care from home to hospital."); YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 59 (noting that international human rights bodies have directed the MMRCs that operate in countries across the globe to move "beyond the medical facts of each individual case [sic] to assess the health system as a whole, through asking questions about the distribution and quality of health facilities in a given region and exploring issues of access to those health facilities"); Yamin, *supra* note 42, at 98 (describing a maternal mortality review as a process "whereby individual deaths of women are investigated with the aim of promoting reflection on institutional and systemic failures as well as individual failures"). In the UK, observers describe MMRCs as performing a "social autopsy," interviewing a range of individuals that have some connection to a maternal death, including "friends, family, and community members." YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 59. The goal of the social autopsy is to identify the "social, behavioral, and health systems contributors to maternal and child deaths." *Id.*

[284] The maternal mortality review process in the UK was able to reduce the national incidence of deep vein thrombosis, or blood clots, after a thorough investigation of each individual case of the complication. *See* Bingham et al., *supra* note 35, at 191. The process culminated in improved assessment of risk for the complication and a recommendation of a prophylaxis, which have "led to fewer deaths from this cause." *Id.*

have acquired the capacity to pinpoint "opportunities for systems change" that might save lives in the future.[285]

The twelve million dollars that the Preventing Maternal Deaths Act allocates annually is primarily designed to fund these state MMRCs.[286] At the time of the passage of the Act, only thirty-six states had formed such committees.[287] Moreover, due to a lack of funding, many of these thirty-six MMRCs were not operating fully.[288] Congress intended the Preventing Maternal Deaths Act to support the creation of MMRCs in the states that had not yet organized them or had allowed the ones that existed to fall into desuetude.[289]

Moreover, Congress also intended the funds that the Preventing Maternal Deaths Act allots to states to address the great variability in the quality of the work that existing state MMRCs are doing. As ProPublica reports, some MMRCs are not very good, "rely[ing] on volunteers to do their work. They publish reports irregularly and, in some cases, do not address the issue of preventability at all."[290] While some MMRCs review all pregnancy-related deaths, others review only a sample of cases.[291] The Act responds to the inconsistency in the quality of state MMRCs by establishing guidelines for the work that these bodies perform.[292]

State MMRCs have the potential to greatly reduce the incidence of maternal mortality in the United States. Observers credit them with accomplishing that very goal in the United Kingdom. The Confidential Enquiries into Maternal Deaths program—which con-

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285 BLACK MAMAS MATTER, *supra* note 40, at 61.

286 Martin, *supra* note 22.

287 *Hearing on H.R. 1318*, *supra* note 264, at 64 (statement of Joia Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative).

288 *Id.* Interestingly, there were more MMRCs in the past. In 1968, forty-five states had MMRCs. *See* YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 57. However, the number fell over the years—owing to the sense that as the maternal mortality ratio dropped, the problem had been solved. *See id.* There are also some indications that state MMRCs shuttered because there was a growing sense that the focus of medical, and societal, attention should be on the fetus, and not necessarily on the woman gestating the fetus. *See id.* By the year 2000, only twenty states had MMRCs. *See id.*

289 *See Hearing on H.R. 1318*, *supra* note 264, at 6 (statement of Rep. Greg Walden) (asserting that the bill would provide support for MMRCs in every state).

290 Martin, *supra* note 22.

291 AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 89.

292 *See* Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, § 2, 132 Stat. 5047, 5048 (codified at 42 U.S.C. § 247b-12 (2018)) (stating that MMRCs receiving federal funds must "include [a] multidisciplinary and diverse membership that represents a variety of clinical specialties" as well as "individuals or organizations that represent the populations . . . that are most affected by pregnancy-related deaths or pregnancy-associated deaths and lack of access to maternal health care services"); *see id.* § 2, 132 Stat. at 5049 (stating that MMRCs must be able to demonstrate to the CDC that they "use best practices to reliably determine and include all pregnancy-associated deaths and pregnancy-related deaths").

ducts the detailed, yet broad-focused investigations into pregnancy-related deaths in the UK that state MMRCs would ideally conduct in the United States—has been responsible for

> decreasing the already low maternal mortality in the United Kingdom via implementation of recommended clinical guidelines. More recently, the system has also been credited with narrowing the gap related to pregnancy outcomes and racial disparities, significantly lowering the maternal mortality among black African women. These positive changes occurred while the maternal population in the United Kingdom faces similar health challenges that face the United States, including an older and less healthy maternal population.[293]

Thus, the potential of the Preventing Maternal Deaths Act is great. However, there are profound limitations that have been built into the Act. The next Part discusses three. First, and most significantly, the Act insists upon *not* naming the racial character of the maternal mortality disaster in the United States. The Act commits a telling racial omission, prompting us to interrogate why this obfuscation came to be and the consequences thereof. Second, the Act fails to embed an allegiance to social justice into itself and, by association, the funds that will be dispensed to state MMRCs in accordance with it. This allows for the MMRCs that the Act commissions, funds, and supports to do work that is not at all in the interests of women at risk of dying during pregnancy, childbirth, or shortly thereafter. Third, the Act can be justifiably accused of fetishizing data. That is, the Act embodies a dangerous commitment to the idea that information, as opposed to action, will save us.

IV
CRITIQUES OF THE PREVENTING MATERNAL DEATHS ACT

A. Racial Erasure

One of the most remarkable aspects of the Preventing Maternal Deaths Act is its omission of the fact that the national shame that is maternal mortality in the United States is a *racial* one.[294]

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[293] Ozimek & Kilpatrick, *supra* note 28, at 181.

[294] In many ways, the Preventing Maternal Death Act represents Congress's adoption of a colorblind lens to address a profoundly racial issue: *racial* disparities in maternal mortality. Insofar as this Article critiques this lamentable colorblindness, it joins a voluminous literature that is highly critical of colorblindness as a political and legal ideology. *See, e.g.*, EDUARDO BONILLA-SILVA, RACISM WITHOUT RACISTS: COLOR-BLIND RACISM AND THE PERSISTENCE OF RACIAL INEQUALITY IN AMERICA (5th ed. 2018) (describing the wide array of "colorblind" arguments and narratives that are used to justify racial inequality); Devon W. Carbado & Cheryl I. Harris, *The New Racial Preferences*, 96 CALIF. L. REV. 1139, 1147–48 (2008) (arguing that colorblind admissions processes

Many scholars, activists, and observers who seek to bring attention to maternal mortality in the United States often point out that the country is doing much worse than other rich, industrialized nations when it comes to keeping pregnant women and new mothers alive.[295] These thinkers and writers frequently underscore that the United States has the highest MMR of all of the developed nations.[296] They emphasize that the MMR in the United States is even higher than some developing nations, a point that this Article explores above.[297] However, the unquestionable reality is that if the United States eliminated racial disparities in maternal mortality—that is, if black women began to die from pregnancy-related causes as (in)frequently as white women—then the MMR in the United States would come to approximate the MMR of countries in the developed world.[298] The United States is a deadly place for women to give birth in large part because it is a dangerous place for *black women* to give birth. The tragedy of maternal mortality in the United States is a profoundly racial tragedy.[299]

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privilege white applicants over applicants of color because the former are less likely to think that their racial identities have played an integral part of their lives and experiences); Neil Gotanda, *A Critique of "Our Constitution Is Color-Blind,"* 44 STAN. L. REV. 1, 2 (1991) (asserting that "color-blind constitutionalism—a collection of legal themes functioning as a racial ideology—fosters white racial domination"); Ian F. Haney López, *"A Nation of Minorities": Race, Ethnicity, and Reactionary Colorblindness*, 59 STAN. L. REV. 985, 1062 (2007) [hereinafter Haney López, *"A Nation of Minorities"*] ("Colorblindness . . . protects and validates as 'not-racism' the actions of intentional discriminators who exercise the smallest modicum of caution as well as, much more significantly, the inertial persistence of entrenched patterns of racial hierarchy."); Ian Haney-López, *Intentional Blindness*, 87 N.Y.U. L. REV. 1779, 1832 (2012) ("The colorblind claim to oppose any government use of race is misleading, for in practice colorblindness opposes race-conscious remedies and nothing more."); Gary Peller, *Race Consciousness*, 1990 DUKE L.J. 758, 762 (1990) (arguing that "conservatives utilize the very rhetoric of tolerance, color-blindness, and equal opportunity that once characterized progressive discourse to mark the limits of reform").

295 *See supra* notes 28–32 and accompanying text.

296 *See, e.g.*, *Hearing on H.R. 1318*, *supra* note 264, at 51 (statement of Lynne Coslett-Charlton, M.D., Pennsylvania District Legislative Chair, American College of Obstetricians and Gynecologists) ("We have higher maternal mortality rates than any other developed country.").

297 *See supra* Section II.A.

298 The MMR among white women in the United States is thirteen per 100,000 live births. Petersen, *Vital Signs*, *supra* note 26, at 424. The World Health Organization estimates that the global average MMR in high-income countries is eleven per 100,000 live births. WORLD HEALTH ORG., TRENDS IN MATERNAL MORTALITY 2000 TO 2017: ESTIMATES BY WHO, UNICEF, UNFPA, WORLD BANK GROUP AND THE UNITED NATIONS POPULATION DIVISION 89 (2019).

299 *See* S. Nadia Hussain, *Addressing Racial Disparities in Maternal Health*, LAW MARGINS https://lawatthemargins.com/addressing-racial-disparities-in-maternal-health (last visited May 31, 2020) ("The bottom line is that the high maternal death and

Nevertheless, the Preventing Maternal Deaths Act wholly obscures this reality. As obstetrician and activist Joia Crear-Perry observed in her congressional testimony in advance of the Act's passage, "[t]hroughout the bill there is no mention of race, racism, or racial disparities."[300] The closest the Act gets to naming the racial nature of the catastrophe is when it states that, among the many reasons for its existence, it is intended "to eliminate disparities in maternal health outcomes for pregnancy-related and pregnancy-associated deaths."[301] In refusing to acknowledge that the disparities around maternal health outcomes that have garnered the media's attention and have been the focus of sustained advocacy are *racial* disparities, the Act allows itself to be understood as one that is about eliminating disparities of all kinds—between older mothers and younger mothers, between those who live in rural areas and those who live in more densely-populated locales, between those who have been pregnant only once and those who are multiparous, etc.[302]

Perhaps more disturbingly, it allows for the work that is conducted under its banner to ignore the race of the epidemic. Which is to say: there may be material consequences that flow from the Act's discursive framing of the issue. One particularly perverse consequence of the Act's racial erasure is that it may cause racial disparities in maternal mortality to *increase*. This perversion will happen if the interventions made as a result of the Act function to save white

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complication rates in our nation cannot be sufficiently addressed without focusing on closing racial disparities . . . .").

[300] *Hearing on H.R. 1318*, *supra* note 264, at 65 (statement of Joia Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative).

[301] Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, pmbl., 132 Stat. 5047, 5048 (codified at 42 U.S.C. § 247b-12 (2018)); *see also Hearing on H.R. 1318*, *supra* note 264, at 65 (statement of Joia Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative) (criticizing the colorblind nature of the Act).

[302] There may be an analogy to the use of the language of "diversity" in the affirmative action context: As Congress was only willing to speak about "disparities" in maternal health outcomes, although it (may have) had *racial* disparities in mind, institutions have only been willing to speak about "diversity," although they have *racial* diversity in mind. *See* Jed Rubenfeld, *Affirmative Action*, 107 YALE L.J. 427, 471 (1997) ("Everyone knows that in most cases a true diversity of perspectives and backgrounds is not really being pursued. . . . The purpose of affirmative action is to bring into our nation's institutions more blacks, more Hispanics, more Native Americans, more women, sometimes more Asians, and so on—period."); Antonin Scalia, *The Disease as Cure: "In Order to Get Beyond Racism, We Must First Take Account of Race,"* 1979 WASH. U. L.Q. 147, 148 (1979) ("When it comes to choosing among these manifold diversities in God's creation, . . . it is a safe bet that though there may not be a piano player in the class, there are going to be close to sixteen minority students.").

women while having no, or only a marginal, effect on the frequency of black maternal deaths.[303]

If a generalized effort to save pregnant women's lives benefits the most privileged, then those who are not privileged will continue to die at the same, or slightly reduced, rates.[304] If those who are most privileged are white, and those who are unprivileged are not white, this would exacerbate racial disparities in maternal deaths. Indeed, there is precedent for this. Eighty years ago, black women were twice as likely as white women to die on the path to motherhood.[305] Today, black women are close to four times as likely as white women to die during pregnancy, childbirth, or shortly thereafter.[306] Although the frequency of maternal deaths has decreased over the past eighty years, racial disparities in maternal mortality have increased. This is due to the simple fact that interventions that we have made to save pregnant women have benefited white women the most.[307]

The lesson here is that *the inability or unwillingness to speak about race and racism risks making attempts to address the effects of racism ineffective*.[308] As it applies to the sad state of black maternal health in the country, the inability to name race in the Preventing Maternal Deaths Act risks making attempts to address the effects of racism—that is, racial disparities in maternal mortality—unsuccessful. This is true even though the Preventing Maternal Deaths Act is likely

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303 *See Hearing on H.R. 1318*, *supra* note 264, at 65 (statement of Joia Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative) ("The [Act's] inability to name [race, racism, or racial disparities] as a key focus to reduce RACIAL disparities in maternal mortality and morbidity will continue to exacerbate the problem."); YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 23 ("Some strategies, if not reviewed with this critical lens, might be more politically feasible, but likely to ignore or increase racial disparities.").

304 *See* YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 23 (identifying the unfortunate consequences of failing to prioritize the needs and experiences of the most marginalized, which occurs when "many interventions work to improve median health by benefiting only certain parts of the population, leaving the most marginalized untouched").

305 *See supra* note 79 and accompanying text.

306 *See supra* note 81 and accompanying text.

307 This precise phenomenon—whereby efforts to reduce maternal mortality result in increases in *racial disparities* in maternal mortality—occurred in New York City. Black women in the city used to be just seven times more likely than white women to die from pregnancy-related causes; they are now twelve times more likely to die. *See* N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, PREGNANCY-ASSOCIATED MORTALITY: NEW YORK CITY, 2006–2010, at 5. Crucially, "[t]he increasing gap was largely driven by a 45% decrease in pregnancy-related mortality among White, non-Hispanic women." *Id.* White women disproportionately benefited from the efforts that New York City made to reduce maternal deaths, which had the effect of increasing racial disparities in maternal mortality in the city.

308 Of course, there is the very valid question of whether it is even accurate to describe the Preventing Maternal Deaths Act as an "attempt to address the effects of racism."

a product of the increased attention that society has given to maternal mortality as a *racialized* problem. The Preventing Maternal Deaths Act is the result of racial inequities having brought attention to the issue of maternal mortality in the country. Nevertheless, in eliding the racial dimensions of the phenomenon, the Act threatens to exacerbate the racial inequities. The irony is profound.

It may be that the authors of the Preventing Maternal Deaths Act ignored the race of the maternal health debacle in the United States in order to affirm that maternal mortality is not "about" race—that it is a deracialized issue. However, as argued above,[309] maternal mortality is already profoundly racialized, as evidenced by the statement that "it" (i.e., a problem of the nonwhite, developing world) should not be happening "here" (i.e., in the white, developed United States).[310] Had the architects of the Preventing Maternal Deaths Act acknowledged race, they might have affirmed their desire to save black lives. In ignoring race, they only managed to affirm their belief that a phenomenon from the nonwhite world has no place in the United States. The discursive chasm between these two possibilities is immense.

The erasure of race in the Preventing Maternal Deaths Act likely explains why the law was "bipartisan." Inattention to the fact that the United States is a dangerous place for *black* women to give birth probably accounts for why it was easy for lawmakers to reach across the aisle and find a point of agreement with lawmakers who share different political commitments.[311]

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309 *See supra* Section II.A.

310 Notably, supporters of the Preventing Maternal Deaths Act publicly made this statement. *See* Ungar, *supra* note 185 (quoting the sponsor of the Preventing Maternal Deaths Act, Rep. Jaime Herrera Beutler, saying, "[t]he numbers [of maternal deaths] are staggering. This is not the developing world. This is the United States of the America").

311 While, as this Section argues, this racial elision does not bode well for the Act actually reducing or eliminating racial disparities in maternal mortality, it also indicates the persistence of the phenomenon whereby things that are identified with people of color are politically unpopular or unsupportable. Much work has been done on the racialization of "welfare." *See generally* MARTIN GILENS, WHY AMERICANS HATE WELFARE: RACE, MEDIA, AND THE POLITICS OF ANTIPOVERTY POLICY (1999). Because many, if not most, associate "welfare" with black people, "welfare" is extremely unpopular. *See id.* The likelihood that there would be a bipartisan law—supported unanimously in both houses of Congress—that involves "welfare" is woefully minuscule in large part because "welfare" is understood as a racial issue, and history has demonstrated the difficulty of building a political consensus around issues that are "about" race. *See, e.g.*, Desmond S. King & Rogers M. Smith, *On Race, the Silence Is Bipartisan*, N.Y. TIMES (Sept. 2, 2011), https://www.nytimes.com/2011/09/03/opinion/on-race-the-silence-is-bipartisan.html (describing how, "[s]ince the end of legal segregation in the 1960s, there have been two approaches to ameliorating racial inequality," one championed by "[c]onservatives and most Republican politicians" and the other supported by "[l]iberals and most Democratic politicians").

Ignoring the racial dimensions of the maternal health tragedy in the United States facilitated its depoliticization,[312] which, in turn, was key to the passage of the Preventing Maternal Deaths Act. The country now evidences a will to know more about maternal deaths in the country. The country might have refused to produce any knowledge around why women are finding the path to motherhood a particularly dangerous road to travel. That is, the government might have embraced a "will not to know" in the context of maternal mortality. This "will not to know" would find precedent in at least one other context: officer-involved homicides. Indeed, the government has decided not to know the number of civilians killed by the police and the circumstances surrounding their deaths.[313]

The following Section explores the government's commitment not to know more about officer-involved homicides. The exploration demonstrates the consequences of a failure to achieve the depoliticization of maternal mortality. Officer-involved homicides demonstrate that information—the mere collection of data—can be a political act. It is because of the particular politicization—indeed, the racialization—of police use of force that the government has committed itself to ignorance about this issue.

In the context of officer-involved homicides, we see the incredible stakes of the Faustian bargain that those working to eliminate the frequency of pregnancy-related deaths faced. Had these advocates insisted upon centering the *racial* nature of the maternal health tragedy in any congressional effort to address it, the effort likely would have died a brutal, partisan death in the halls of Congress. So, they acquiesced to a racial erasure. However, while this acquiescence might have enabled the congressional effort to address maternal mortality to become law, the racial erasure presages the inability of the

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[312] It is inaccurate to say that ignoring the racial dimensions of the sad state of maternal health in the United States—that is, approaching the issue through a colorblind lens—functions to "depoliticize" the issue. This is because colorblindness is itself a political strategy. *See* Haney López, *"A Nation of Minorities," supra* note 294, at 1062 (noting that colorblindness has been deployed to protect the race-neutral processes that produce and reiterate racial inequality and hierarchy). More accurately, ignoring the racial dimensions of maternal mortality in this country allowed the issue to be politicized in a particular way—one that was acceptable to politicians with variable political commitments.

[313] It may be that when the aggrieved parties are white—or are imagined to be white—the government develops a "will to know" the phenomenon. *See, e.g.*, Yuvraj Joshi, *Measuring Diversity*, 117 COLUM. L. REV. ONLINE 54, 56, 60 (2017), https://columbialawreview.org/wp-content/uploads/2017/03/Joshi-vFinal-031317-2.pdf (noting that when "typically white applicants . . . are denied admission . . . and bring cases that challenge racial preferences in college admissions, . . . their political resistance becomes inscribed into law," and the Court develops a "concern with numbers," demanding that colleges and universities measure the levels of diversity that their race-conscious programs achieve).

law to be an effective tool in the fight against a *racial* injustice, as argued above. In essence, the phrase "damned if you do, damned if you don't" ably describes the situation that activists for black maternal health encountered.

1. What Officer-Involved Homicides Can Teach Us About the Politics of Racial Erasure

Officer-involved homicides present a revealing analogy to the maternal mortality context. As explored below, observers have claimed that collecting data about maternal deaths is the "first step" towards preventing pregnancy-related deaths.[314] Similarly, observers who believe that police violence is a problem have also claimed that collecting data about officer-involved homicides is the "first step" towards preventing these deaths.[315] As Ben Brucato writes,

> there is a sense that better methods of collecting, analyzing, and reporting on use-of-force incidents is a necessary early step to fulfill prior to intervention. [Many] treat the problem of police violence as a knowledge problem. Data is treated as offering some unique access to certain knowledge, without which neither governments nor publics could legitimately act to intervene. Among those in government, academics, journalists, and many activists, police use of force is a social problem to be resolved through better data collection, analysis, and reporting. This discursive maneuver articulates a view of transparency in which *databases enable and legitimate social and political action*. By implication, this work also functions to communicate that action may be illegitimate without recourse to data.[316]

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[314] *See* discussion *infra* notes 373–75 and accompanying text.

[315] *See* Trymaine Lee & Safia Samee Ali, *Why Doesn't the Government Track Nationwide Police Use of Force?*, NBC NEWS (Nov. 14, 2016, 4:46 AM), https://www.nbcnews.com/news/us-news/why-doesn-t-government-track-nationwide-police-use-force-n682626 (quoting a civil rights attorney as saying "the more data you have, the more evaluations and judgments you can make on reform" and "[w]ithout [data] you're at a loss"); *id.* (quoting an advocate for police reform as saying "[y]ou can't fix what you can't measure"); Tom McCarthy, *The Uncounted: Why the US Can't Keep Track of People Killed by Police*, GUARDIAN (Mar. 18, 2015), https://www.theguardian.com/us-news/2015/mar/18/police-killings-government-data-count (noting that a government count of the number of deaths "that happened in the presence of a local or state law enforcement officer," "was more than a count of killings by police," as "[i]t was meant to be the elusive key to a problem"); *id.* (noting that after the uprising in Ferguson that occurred after a police officer killed Michael Brown, then-President Obama "spoke of the 'need to collect more data'"); Brian Karl Finch, *Police Homicides in the United States*, U. SOUTHERN CAL. SCHAEFFER: THE EVIDENCE BASE (May 2, 2018), https://healthpolicy.usc.edu/evidence-base/police-homicides-in-the-united-states ("The first step in reducing police homicides was to document the extent of the problem.").

[316] Ben Brucato, *Big Data and the New Transparency: Measuring and Representing Police Killings*, 4 BIG DATA & SOC. 1, 3–4 (2017) (emphasis added).

Currently, the government does not collect systemic data about officer-involved homicides. There is no doubt that the government *could* collect this data if it wanted to. Commentators have observed that the government collects robust, complete data on an assortment of issues, ranging from the significant—like the number of people who have died from pneumonia, influenza, measles, malaria, mumps, and Hepatitis A[317]—to the not-so-significant. As colorfully described in *The Guardian*:

> The federal government counts many things well. . . . It counts the average number of hours American men spend weekly on lawn care (almost two). It counts the monthly production of hens' eggs (8.31bn in November). It counts nut consumption by non-Hispanic white men over the age of 20 (42.4% enjoyed nuts on any given day in 2009-2010).[318]

Accordingly, the government's failure to engage in systemic data collection on the issue of officer-involved homicides is not an issue of capability but of will. Notably, the government has compiled accurate statistics about the number of police officers killed in the line of duty; in telling contrast, no reliable government-produced statistics exist about the number of civilians killed by the police.[319]

It is stating the obvious to observe that the question of police use of force is politicized.[320] This is true, in large part, because the issue is

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317 *See* Nancy Krieger, Jarvis T. Chen, Pamela D. Waterman, Mathew V. Kiang & Justin Feldman, *Police Killings and Police Deaths Are Public Health Data and Can Be Counted*, 12 PLOS MED. 1, 2 (Dec. 8, 2015).

318 McCarthy, *supra* note 315; *see also* Lee & Ali, *supra* note 315 ("Even in an age of exhaustive monitoring of everything from public school competency to national park attendance, there is no single government agency tasked with collating data on how often police injure citizens.").

319 *See* Krieger et al., *supra* note 317, at 1–2 ("[A]lthough the number of US law enforcement agents killed in the line of duty is well documented . . . no reliable official data exist on the number of US persons killed by the police."); *see also* James Bovard, *Under Four Presidents, the Feds Neglected Duty to Collect Statistics on Police Killings*, USA TODAY (June 11, 2020, 1:23 PM), https://www.usatoday.com/story/opinion/2020/06/11/george-floyd-police-killings-violence-neglected-federally-column/5320501002 (noting that despite legislative attempts to collect data on officer-involved homicides, such as the Violent Crime Control and Law Enforcement Act and the Death in Custody Reporting Act, "[f]ederal criminal neglect of police killings has continued for more than 25 years under both Democratic and Republican administrations").

320 *See, e.g.*, Anna Brown, *Republicans More Likely than Democrats to Have Confidence in Police*, PEW RES. CTR.: FACT TANK (Jan. 13, 2017), https://www.pewresearch.org/fact-tank/2017/01/13/republicans-more-likely-than-democrats-to-have-confidence-in-police (finding that about three-quarters of Republicans believe that police are "using the right amount of force for each situation" while only about a quarter of Democrats agree). The killing of George Floyd by the police has made the politicization of police use of force all the more obvious. *See* Paul Kane & John Wagner, *Democrats Unveil Broad Police Reform Bill as Floyd's Death Sparks Protests Nationwide*, WASH. POST (June 9, 2020, 10:24 AM), https://www.washingtonpost.com/powerpost/democrats-unveil-broad-police-reform-bill-

racialized. Society has come to understand the phenomenon of officer-involved homicides as one that is about the deaths of unarmed black men at the hands of white police officers.[321] (This is true although black women, too, are often killed by police.[322]) The most familiar names of the victims of officer-involved homicides all, or mostly, belong to black men (or boys): Michael Brown, Philando Castile, Alton Sterling, Stephon Clark, Tamir Rice, Freddie Gray, and George Floyd.[323] The racialization of officer-involved homicides has politicized the phenomenon. Where one stands on the issue of officer-

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pledge-to-transform-law-enforcement/2020/06/08/1ed07d7a-a992-11ea-94d2-d7bc43b26bf9_story.html (contrasting Democrat and Republican responses to police reform); Claudia Grisales, Kelsey Snell & Susan Davis, *Senate Democrats Block GOP Police Reform Bill*, NPR (June 24, 2020, 12:58 PM), https://www.npr.org/2020/06/24/882530458/democrats-vow-to-block-gop-police-reform-bill-unless-republicans-agree-to-negoti ("[T]he GOP bill does not outlaw chokeholds, neck holds, carotid holds or other maneuvers, an area where Democrats are not willing to bend.").

321 *See, e.g.*, Devon W. Carbado & L. Song Richardson, *The Black Police: Policing Our Own*, 131 HARV. L. REV. 1979, 1989 (2018) (reviewing JAMES FORMAN JR., LOCKING UP OUR OWN: CRIME AND PUNISHMENT IN BLACK AMERICA (2017)) ("Discussions about race and policing almost always have as their predicate the idea that the agents of racial profiling and police violence are white."); L. Song Richardson, *Police Racial Violence: Lessons from Social Psychology*, 83 FORDHAM. L. REV. 2961, 2961–62 (2015) ("[P]olice killing [of] unarmed black men has brought national attention to the persistent problem of policing and racial violence. . . . Data reported to the FBI indicate that white police officers killed black citizens almost twice a week between 2005 and 2012.").

322 *See generally* KIMBERLÉ WILLIAMS CRENSHAW & ANDREA J. RITCHIE WITH RACHEL ANSPACH ET AL., CTR. FOR INTERSECTIONALITY & SOC. POLICY STUDIES, AFR. AM. POLICY FORUM, SAY HER NAME: RESISTING POLICE BRUTALITY AGAINST BLACK WOMEN (2015). While numerous examples abound of black women dying at the hands of police and, as compared to black men, receiving little to no justice or wide-scale public outcry, recent police killings acutely expose this disparity. The death of George Floyd sparked global protests and resulted in the relatively swift firing and criminal charging of the four officers involved. *Protests Across the Globe After George Floyd's Death*, CNN: WORLD (last updated June 13, 2020, 3:22 PM), https://www.cnn.com/2020/06/06/world/gallery/intl-george-floyd-protests/index.html; Rich Shapiro, *How the Officers Charged in George Floyd's Death Could Get Their Jobs Back*, NBC (June 27, 2020, 6:01 AM), https://www.nbcnews.com/news/us-news/how-officers-charged-george-floyd-s-death-could-get-their-n1232236 (noting the officers' respective firings and criminal charges). Meanwhile, the three policemen who killed Breonna Taylor in her own home, as she lay sleeping, have yet to be criminally charged and only one has been fired to date. Anna North & Fabiola Cineas, *Protests Across the Globe After George Floyd's Death*, VOX (July 13, 2020, 12:36 PM), https://www.vox.com/2020/5/13/21257457/breonna-taylor-louisville-shooting-ahmaud-arbery-justiceforbreonna ("The four officers involved in the killing of George Floyd were fired four days after Floyd's death . . . . By contrast, not much has happened in Taylor's case.").

323 Sarah Almukhtar et al., *Black Lives Upended by Policing: The Raw Videos Sparking Outrage*, N.Y. TIMES, https://www.nytimes.com/interactive/2017/08/19/us/police-videos-race.html (last updated April 19, 2018) (collecting videos of police killings of, and violence against, unarmed black people); *see Breonna Taylor: Timeline of Black Deaths Caused by Police*, BBC (Sept. 23, 2020), https://www.bbc.com/news/world-us-canada-52905408 (highlighting nine high-profile police killings since 2014, only one of which involves a black woman).

involved homicides—whether one thinks they represent racism at its most brutal or the unfair vilification of heroes who do not wear capes—evidences a political commitment.[324]

Because of the politicization of officer-involved homicides, society has come to understand that the choice to collect data about the issue is a political decision that *there is an issue*—that the number of people that police have killed is unacceptably high or that the police need to be monitored more closely. Gathering data about police killings has come to be a political claim that the police ought not to be left to police themselves—that outside entities ought to hold police officers and police departments accountable for their use of force.[325] Accordingly, we can understand the government's refusal to engage in data collection about this issue as an opposing political position. It is a position in which the government has sided with those on one side of the political divide—the side that believes that any scrutiny of the police is unadvisable, unwanted, and unnecessary.[326]

This is not to say that the government has made no overtures towards collecting data on police killings. The Bureau of Justice Statistics (BJS), Federal Bureau of Investigation (FBI), and Centers for Disease Control and Prevention all have had separate programs that have attempted to gather information about police use of force.[327] However, the programs have all been inadequate, and the data that they have generated have been unreliable, as they all have depended either on police departments and states volunteering information about police use of force or on reports by medical examiners and coroners.[328] The BJS ultimately abandoned its attempt to collect data on police use of force on account of the woefully incomplete

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[324] *See, e.g.*, Dara Lind, *How "Blue Lives Matter" Went from a Reactive Slogan to White House Policy*, VOX (Feb. 9, 2017, 3:50 PM), https://www.vox.com/policy-and-politics/2017/2/9/14562560/trump-police-black-lives (noting the rise of a "culture war" between racial justice advocates and law enforcement).

[325] *See, e.g.*, Paul Kane & John Wagner, *Democrats Unveil Broad Police Reform Bill as Floyd's Death Sparks Protests Nationwide*, WASH. POST (June 9, 2020, 10:24 AM), https://www.washingtonpost.com/powerpost/democrats-unveil-broad-police-reform-bill-pledge-to-transform-law-enforcement/2020/06/08/1ed07d7a-a992-11ea-94d2-d7bc43b26bf9_story.html.

[326] *See* Lind, *supra* note 324 (discussing the "powerful" idea that "criticism of police officers puts their lives in danger," which has been broadly supported by conservatives and has fueled the "Blue Lives Matter" response).

[327] *See* McCarthy, *supra* note 315.

[328] *See id.* (explaining that the BJS and FBI rely on police departments, localities, and states while the CDC looks to medical examiners and coroners); *see also* Brucato, *supra* note 316, at 2 ("[T]he Violent Crime Control and Law Enforcement Act of 1994 established a federal mandate for the collection and reporting on use of force by police in the United States. . . . [But] there are no requirements that local police departments provide requisite data.").

information that it was receiving from the few police departments that elected to respond to its request for data.[329] However, before calling off the project, the BJS had compiled enough information to conclude that the FBI's numbers on police killings were a substantial undercount.[330] Indeed, in almost a decade's worth of data, the BJS estimated that the FBI was missing at least *half* of those whom the police have killed.[331]

In 2014, as a partial response to the public outcry that the police killing of Michael Brown in Ferguson, Missouri sparked, Congress passed the Death in Custody Reporting Act of 2013 (DICRA).[332] DICRA reauthorized the Death in Custody Reporting Act of 2000, which required certain state agencies to report deaths that occur while an individual is in state custody,[333] including, after 2003, arrest-related deaths.[334] Expiring in 2006, this predecessor statute gave rise to the BJS's inconsistent and ultimately unsuccessful data-collection efforts, discussed above.[335] In an effort to "restore" that earlier law,[336]

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329 *See* McCarthy, *supra* note 315 ("With some states never participating, and major police departments such as the NYPD failing to report for some years, [BJS] statisticians were never satisfied with their data pool. In March of [2014], the bureau pulled the plug on the project . . . .").

330 *See id.* ("[The BJS program] allowed the statisticians to estimate just how bad the FBI's numbers were.").

331 *See id.* ("The FBI was counting fewer than half of homicides by police officers, BJS discovered. From 2003 to 2009, plus 2011, the FBI counted an average of 383 'justifiable homicides by law enforcement' each year. The actual number, as estimated by the BJS study, was closer to 928.").

332 *See* Steve Horn, *Report Finds Lack of Reporting on Deaths in Law Enforcement Custody, Even After Landmark Legislation*, CRIM. LEGAL NEWS (July 17, 2019), https://www.criminallegalnews.org/news/2019/jul/17/report-finds-lack-reporting-deaths-law-enforcement-custody-even-after-landmark-legislation ("Passage of The Death in Custody Reporting Act of 2013 in December 2014 came in the aftermath of the shooting of Michael Brown, an unarmed black teen in Ferguson, Missouri. . . . In turn, some began calling it the 'Ferguson Bill.'").

333 *See* Deborah M. Golden, *Looking Behind the Locked Door: Prison Law Reform Proposals for the New Administration*, 3 HARV. L. & POL'Y REV. ONLINE 1, 7–8 (2008) ("Before it expired in 2006, the Act required state agencies that received federal funds to report basic information about any deaths that occurred while a person was in state custody."); Grace E. Leeper, Note, *Conditional Spending and the Need for Data on Lethal Use of Police Force*, 92 N.Y.U. L. REV. 2053, 2088 (2017) ("DICRA was first passed in 2000, but expired in 2006 and was not revived until 2013."); Bryan Schatz & Allie Gross, *Congress Is Finally Going to Make Local Law Enforcement Report How Many People They Kill*, MOTHER JONES (Dec. 17, 2014), https://www.motherjones.com/politics/2014/12/death-custody-reporting-act-police-shootings-ferguson-garner ("The bill . . . is the reauthorization of the original act, passed in 2000.").

334 *See* Schatz & Gross, *supra* note 333 ("[L]awmakers inserted a provision requiring tallies of arrest-related deaths in 2003.").

335 *See* Franklin E. Zimring, *How Many Killings by Police?*, 2016 U. CHI. LEGAL F. 691, 698–99, 706 (describing the predecessor statute's authorization of BJS to collect information about arrest-related deaths, and noting that, after the statute's expiration in

DICRA purported to require police departments to report to the Attorney General all cases in which an individual died while in police custody.[337] While supporters of DICRA submitted that the law addressed the lack of high-quality information surrounding police use of force,[338] DICRA, like all of the federal government's existing data collection programs, did not oblige police departments or individual states to send the Attorney General the relevant data. Instead, DICRA gave the Attorney General the *option* of withdrawing a small portion of the federal funds that states receive if they failed to comply with reporting requests.[339] Indeed, one proposed (but unrealized) iteration of DICRA would have had the BJS supplement state-produced data with open-source information, suggesting a recognition of DICRA's inability to prompt complete reporting by states.[340] What is more, implementation of data-gathering under DICRA has faced substantial delay, even though the statute itself requires implementation by 2016.[341] In 2018, after a transfer of responsibility from the BJS to

2006, the BJS's efforts became an "orphan program that was continued at lower visibility and effort"); Schatz & Gross, *supra* note 333 (discussing the Justice Department's failures to enforce the statute's penalties and incentivize states to file reports); *see also* OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, REVIEW OF THE DEPARTMENT OF JUSTICE'S IMPLEMENTATION OF THE DEATH IN CUSTODY REPORTING ACT OF 2013, at 10 (2018), https://www.oversight.gov/sites/default/files/oig-reports/e1901.pdf ("[A]n assessment of its historical Arrest-Related Death . . . Program indicated that BJS had been collecting only about 50 percent of all law enforcement homicides for its 2003–2009 and 2011 collections.").

336 OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, *supra* note 335 (stating that DICRA "restored and expanded" its predecessor statute).

337 *See* 34 U.S.C. § 60105(a) (2018); *see also* Lee & Ali, *supra* note 315 (suggesting the Act has not been effective in gathering information).

338 *E.g.*, Press Release, Congressman Bobby Scott, Senate Passes Death in Custody Reporting Act (Dec. 11, 2014), https://bobbyscott.house.gov/media-center/press-releases/senate-passes-death-in-custody-act (quoting Senator Richard Blumenthal's view that "[t]his legislation will fix that unacceptable factual gap [in reliable information]").

339 *See* 34 U.S.C. § 60105(c)(2) (2018) ("[A] State that fails to comply with subsection (a), shall, at the discretion of the Attorney General, be subject to not more than a 10-percent reduction of the funds . . . ."); *see also* 9to5, National Association of Working Women et al., Comment Letter on Proposed Implementation of Deaths in Custody Reporting Act (DICRA) 2 (Oct. 3, 2016), https://www.amnestyusa.org/pdfs/DICRA%20Coalition%20Comments.pdf (stating that DICRA only "gives the Attorney General the discretion to subject states that do not report deaths in custody to a ten percent reduction of Edward Byrne Memorial Justice Assistance Grant Program . . . funds").

340 *See id.* at 1–2 (stating that the proposed implementation of DICRA suggests that the BJS will "rely primarily upon publicly available information" like "news sources"); 81 Fed. Reg. 51,489, 51,490 (Aug. 4, 2016) (describing a redesigned BJS methodology which explicitly relies on "open sources"); OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, *supra* note 335, at 11 ("This methodology would use both open-source and local agency-reported data in an effort to increase the capture of reportable deaths.").

341 *See* 34 U.S.C. § 60105(f)(2) (2018) (requiring the Attorney General to submit a report to Congress "[n]ot later than 2 years after December 18, 2014," detailing the

the Bureau of Justice Assistance (BJA),[342] the Department of Justice implemented a reporting program under DICRA that commentators have condemned for abandoning earlier, more robust proposals for assembling data (including the use of open-source data).[343] Voluntary reporting under this program began in 2019[344]—three years after the deadline in the statute and five years after enactment—and there appear to be no plans to make the data public.[345] To those holding the political view that police use of force is a problem, DICRA is wildly insufficient—a continuation of the government's will not to know.[346]

It deserves underscoring that to date, DICRA still has not been fully implemented.[347] Ultimately, the federal government has decided against using its spending powers to encourage individual police departments and states to provide information about how often and under what circumstances police officers kill someone.[348] Observers

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findings of a study of information gathered from states); OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, *supra* note 335, at 10 (noting this delay).

342 *See* OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, *supra* note 335, at 11 (explaining that the switch was due, among other things, to an Office of Management and Budget requirement for "statistical agencies to operate separately from policy-making activities"); *see also* Ethan Corey, *How the Federal Government Lost Track of Deaths in Custody*, APPEAL (June 24, 2020), https://theappeal.org/police-prison-deaths-data (noting a "prohibit[ion on] the government from using BJS data for law enforcement purposes").

343 *See* American Civil Liberties Union et al., Comments in Response to Notice Regarding "Agency Information Collection Activities; Proposed eCollection eComments Requested; New Collection: Death in Custody Reporting Act Collection," at 3 (Aug. 29, 2018), https://www.aclu.org/sites/default/files/field_document/dcra_sign_on_9-28-18.pdf; Corey, *supra* note 342 (noting various commentators' views that the implementation will prove ineffective); *see also* OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, *supra* note 335, at 13–19 (listing numerous factors that could make data collection under the implementation "duplicative and incomplete").

344 *See* BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, DEATH IN CUSTODY REPORTING ACT PERFORMANCE MEASUREMENT TOOL – FREQUENTLY ASKED QUESTIONS 2 (2020), https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/DCRA-FAQ_508.pdf (noting that a state's reporting obligations would begin in 2019); *see also* Bureau of Justice Assistance, *Edward Byrne Memorial Justice Assistance Grant (JAG) Program: Reporting Requirements*, U.S. DEP'T OF JUSTICE (Dec. 9, 2019), https://bja.ojp.gov/program/jag/reporting-requirements ("Beginning in FY 2019, BJA will require reporting from states pursuant to DCRA.").

345 *See* BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, *supra* note 344, at 3 ("The Office of Justice Programs will maintain this information internally, however some data may be subject to the Freedom of Information Act."); Corey, *supra* note 342 (noting a BJA spokesperson's recent statement that no such plans to make the data public exist).

346 *See, e.g.*, Roxanne Ready, Hannah Gaskill & Nora Eckert, *Government Fails to Release Data on Deaths in Police Custody*, ASSOCIATED PRESS (June 19, 2019), https://apnews.com/de404fd6795d4a61bc72c7df188eb9cd (noting the concern of advocacy groups that "the lack of accountability is letting law enforcement officials off the hook").

347 Kristina Roth, *Police Use of Excessive Force*, AMNESTY INT'L U.S., https://2020electionscovid.amnestyusa.org/police (last visited July 19, 2020).

348 *See* New York v. United States, 505 U.S. 144, 161–62, 171–73 (1992) (affirming that the Spending Clause allows Congress to encourage states' regulation of hazardous waste).

have noted that the federal government could make federal funding contingent on police departments' compiling the relevant information and submitting it to the appropriate federal agencies.[349] Alternatively, the federal government might provide funds to police departments to subsidize their efforts to compile the desired information. Indeed, observers have noted that some police departments may have failed to participate in the federal government's information collection efforts because it would have been financially burdensome to do so.[350] However, the federal government has done neither—leaving the data that it collects about police killings radically incomplete as well as sending a clear message about where it stands on the political question of the "problem" of police use of force.[351]

To return to the issue of maternal mortality, political support of the Preventing Maternal Deaths Act likely depended on its refusal to name the racial dimensions of this country's maternal health catastrophe. The Act's very passage might have depended on its attempt to deracialize maternal mortality—an attempt at deracialization that might have functioned to depoliticize the issue. A pragmatist may argue that this un-naming is defensible. And in light of the lessons taught by the government's will not to know much about the profoundly racialized issue of officer-involved homicides, the pragmatist certainly has a point.[352] The racialization, and consequent politiciza-

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[349] *See* 9to5, National Association of Working Women et al., *supra* note 339, at 1 (requesting "that the Office of Justice Programs . . . condition federal criminal justice grants on data collection and reporting on police-community encounters").

[350] *See* Brucato, *supra* note 316, at 2 ("In 2011, FBI spokesperson William Carr claimed . . . that budgetary and practical factors would prohibit police officers and agencies from collecting the data."); McCarthy, *supra* note 315 (stating that Georgia, Montana, and Maryland refused to participate in the BJS's data collection program because participation "could mean extra work and compliance headaches" and stating that "Washington DC dropped out of the program as resources and willpower dwindled").

[351] It is worth noting that the death of George Floyd, and the mobilization it has inspired, has resulted in an unprecedented focus on police use of force by both political parties. *See* JOANNA R. LAMPE, CONG. RESEARCH SERV.: LEGAL SIDEBAR, COMPARING POLICE REFORM BILLS: THE JUSTICE IN POLICING ACT AND THE JUSTICE ACT 1, 2, 4 (2020), https://crsreports.congress.gov/product/pdf/LSB/LSB10498 (describing subjects covered by both Democratic and Republican bills as including, among others, "[l]imitations on chokeholds and other uses of force" and "[r]eporting on use of force").

[352] Officer-involved homicides and maternal mortality share another similarity: As noted below, there are compelling arguments that we already know how to prevent pregnancy-related deaths. *See infra* Section IV.C. Similarly, there are compelling arguments that we *already know* how to prevent officer-involved homicides. Indeed, scholars have devoted much time and effort to examining the legal determinants of police violence—that is, how the laws concerning when and how police can engage with citizens enable deadly police encounters. *See, e.g.*, Devon W. Carbado, *Blue-on-Black Violence: A Provisional Model of Some of the Causes*, 104 GEO. L.J. 1479 (2016) (advancing a multipart model that accounts for how social and legal forces enable and perpetuate police violence against black people); Devon W. Carbado, *From Stopping Black People to Killing Black*

tion, of an issue may be the equivalent of a death knell for congressional action. To the extent that attempting to erase race from the fact of maternal mortality in the United States achieved its depoliticization, then this racial erasure breathed life into the Preventing Maternal Deaths Act. However, as argued above, there is a compelling argument to be made that the Act's racial erasure will function to make it an ineffectual tool in the effort to eliminate *racial disparities* in maternal mortality. Again, the inability to speak about racism oftentimes makes attempts to address the effects of racism ineffective.

Further, there is a compelling argument to be made, and critical race theorists have made it often, that the nation's refusal to name race functions to perpetuate racial inequities and injustices in the post-Civil Rights present.[353] If so, then we should expect that the racial un-naming that the Preventing Maternal Deaths Act performs will function to maintain existing racial stratification.

People: The Fourth Amendment Pathways to Police Violence, 105 CALIF. L. REV. 125 (2017) (explaining how Fourth Amendment doctrine creates preconditions for police violence against, and police killings, of black Americans); Stephen Rushin, *Federal Enforcement of Police Reform*, 82 FORDHAM L. REV. 3189, 3192–94 (2014) (examining how the DOJ has underenforced a federal regime for promoting structural police reform through pattern-or-practice litigation). Scholars have also explored how the failure to hold police accountable for injuring and killing citizens—inasmuch as the federal government does not monitor police departments' use of force and juries very rarely hold individual officers legally responsible for the force they use—allows for the status quo to continue. *See, e.g.*, Joseph B. Richardson, Christopher St. Vil & Carnell Cooper, *Who Shot Ya? How Emergency Departments Can Collect Reliable Police Shooting Data*, 93 J. URB. HEALTH S8, S10 (2015) ("[T]he Department of Justice keeps no comprehensive database or record of police shootings from the roughly 18,000 law enforcement departments in [sic]USA."); Kate Levine, *Who Shouldn't Prosecute the Police*, 101 IOWA L. REV. 1447, 1464–65 (2016) (describing the "already-existing statutory and credibility barriers" that contribute to "why so few officers are indicted, let alone convicted, of criminal acts"). Just as we might argue in the context of maternal deaths that the problem is not one of knowledge, but rather the *will* to organize society differently, we might make the same argument in the context of police killings. In light of recent officer-involved homicides, like those of George Floyd, Breonna Taylor, Tony McDade, Rayshard Brooks, and countless others, this argument becomes all the more cogent.

353 Khiara M. Bridges, *Class-Based Affirmative Action, or the Lies that We Tell About the Insignificance of Race*, 96 B.U. L. REV. 55, 58–60, 94–97 (2016) (discussing the use of class-based affirmative action to deny the reality of continued racial inequity). In the context of admissions to colleges and universities, for example, critical race theorists have observed that aversion to naming race functions to perpetuate racial inequity in that process. *See Introduction* to CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT, at xiii, xiv–xvi, xxix (Kimberlé Crenshaw, Neil Gotanda, Gary Peller & Kendall Thomas eds., 1995). ("[C]ertain conceptions of merit function not as a neutral basis for distributing resources and opportunity, but rather as a repository of hidden, race-specific preferences for those who have the power to determine the meaning and consequences of 'merit.'"). Furthermore, the failure to address race bolsters the popular conception that the "current distribution of access, power, privilege, and disadvantage is just the way things are." Kimberlé Crenshaw, *The Court's Denial of Racial Societal Debt*, 40 HUM. RTS. 12, 12–13 (2013).

B. The Political Agnosticism of the Preventing Maternal Deaths Act and the Variable Political Commitments of State MMRCs

That a state has an MMRC should not be taken as unimpeachable evidence that the state has pregnant women's best interests at heart. If the state directs the MMRC that it establishes to engage in a wide-ranging investigation into how social structures and institutions interacted with individual behavior to produce a maternal death, then the MMRC will do the work that advocates for better maternal health outcomes believe needs to be done to bring the United States' MMR down to defensible levels. If, however, the state provides limited direction to its MMRC, it leaves the political commitments of those who staff the committee to inform the work that the committee does. In that case, there are no assurances that the MMRC will do the critical work that will preserve women's lives. Notably, there is nothing in the Preventing Maternal Deaths Act demanding that the state MMRCs that the Act funds do this critical work.

The Congress that passed the Preventing Maternal Deaths Act knew perfectly well how to direct MMRCs to pay attention to the things that it thought important. Consider the issue of confidentiality. The Act takes care to require that MMRCs that participate in the program establish guidelines for the confidentiality of the review process.[354] It requires MMRCs to "develop a process" that allows for healthcare providers, medical examiners, family members, and other affected persons to confidentially report the deaths of women from a pregnancy-related cause.[355] Additionally, it obligates states to "establish confidentiality protections" that ensure that identifying information about women who died from pregnancy-related causes and "information from committee proceedings" are not made public.[356] These provisions were likely included because the authors of the Act understood that confidentiality is essential to the process of reviewing maternal deaths. Individuals and institutions who provide obstetrical care to pregnant women may not be supportive or responsive to the requests of MMRCs if they fear that an MMRC review might open them up to litigation and liability.[357] A confidential review process may provide the assurance that many need if they are to back the work that an MMRC does in a state and to comply with an investiga-

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354 *See* Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, sec. 2(5), § 317K(d)(2), 132 Stat. 5047, 5049 (codified at 42 U.S.C. § 247b-12(d)(2) (2018)).

355 *Id.* sec. 2(5), § 317K(d)(2)(A)–(B), 132 Stat. at 5049.

356 *Id.* sec. 2(5), § 317K(d)(4), 132 Stat. at 5050.

357 *See* AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 89 (acknowledging this risk).

tion that an MMRC conducts.[358] Prior to the Preventing Maternal Deaths Act, some states with MMRCs had no such confidentiality protections.[359] Congress took aim at this flaw, making explicit its understanding that confidentiality is an essential aspect of an effective maternal mortality review process.

With this in mind, what are we to make of the fact that the Act simply tells state MMRCs, in the vaguest and most general of terms, "to identify adverse outcomes that may contribute to . . . pregnancy-related death, and to identify trends, patterns, and disparities in such adverse outcomes to allow the [government] to make recommendations . . . to improve maternal care and reduce . . . pregnancy-related death"?[360] What are we to make of the fact that the Act says nothing about institutions, structures, or systems that make pregnancy and childbirth unsafe for women in the United States? Congress was convinced that confidentiality was an essential component of an effective maternal death review process. In contrast, Congress appears unconvinced that institutional, structural, or systemic transformation is an essential component of an effective response to maternal deaths in the United States.

The importance of MMRCs' taking a critical approach to the issue of maternal mortality and committing themselves to investigating structural causes of the United States' elevated ratios of maternal death is laid bare when one considers Louisiana's MMRC. In its earlier iterations, the commission seemed interested in laying the blame for maternal deaths at the feet of the women dying during pregnancy[361]—a problem that Section II.C identified as a feature of the general discourse around maternal mortality in the United States.[362] The committee paid very little attention to the conditions under which women lived.[363] It did not inquire about women's ability

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[358] *But see id.* at 90 ("[E]ven in those states [with confidential review processes] providers apparently remain concerned that the protections are not sufficient to shield them from litigation.").

[359] *See id.* at 89–90 (noting that three of the twenty-one states with MMRCs at the time of publication did not "have legal or administrative protections for the confidentiality of information disclosed for public health investigations").

[360] *See* Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, sec. 2(5), § 317K(d)(3)(B), 132 Stat. 5047, 5049.

[361] *See* LA. DEP'T OF HEALTH & HOSPS., *supra* note 217, at 10–11 (suggesting intensive monitoring of, or attention to, several conditions and comorbidities that the commission found were linked to maternal death).

[362] *See supra* Section II.C (discussing researchers' and experts' misguided focus on explanations for high maternal mortality that center exclusively on the role of mothers' compromised health).

[363] *See* LA. DEP'T OF HEALTH & HOSPS., *supra* note 217 (failing to discuss structural factors in its causal analysis).

to access healthcare. It did not interrogate whether lives might have been saved if hospitals and physicians altered the way that they delivered care. Were hospitals responding to emergencies in the most effective way possible? Were practices in place for identifying the development or worsening of life-threatening conditions, like high blood pressure or excessive blood loss? Were women given information about signs that they should look out for—signs that, when present, mean that a woman should go immediately to her healthcare provider? Were providers listening to the symptoms that women reported?

Instead of asking these questions, the earlier iteration of Louisiana's MMRC asked what *women* were doing that led to pregnancy complications. Accordingly, the report that the commission issued noted that if the state was going to lower its MMR, women needed to stop smoking and lose weight.[364] Louisiana's MMRC was willing to look in many places to find ways to reduce the number of women who die during pregnancy and yet largely overlooked the healthcare delivery system in the state.[365] The MMRCs in Georgia, Michigan, Minnesota, Missouri, and Virginia have taken a similarly narrow view by focusing on what women are doing to cause pregnancy complications.[366]

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[364] *See id.* at 10 (identifying "smoking" and "obesity" as the "principle [sic] modifiable clinical risk indictors"—which assumes that other risk indicators are not modifiable); *see also* Ungar, *supra* note 185 ("In Louisiana—the deadliest state in America for pregnant women and new mothers—the state's 2012 report on maternal deaths emphasized suicide, domestic violence and car crashes. It dedicated pages of charts and recommendations to those issues.").

[365] Louisiana's MMRC recommended that, because many pregnancy-associated deaths are due to interpersonal violence, law enforcement should be represented on the committee that reviews maternal deaths. *See* LA. DEP'T OF HEALTH & HOSPS., *supra* note 217, at 10 ("Due to the large number of pregnancy-associated homicide deaths . . . the committee recommended the incorporation of law enforcement/criminal justice system representatives as key stakeholders and participants in the [pregnancy-associated mortality] review process."). Inasmuch as most MMRCs do not involve police officers, the Louisiana MMRC was capable of imagining creative interventions to save women's lives. (Of course, responding to interpersonal violence with law enforcement and the criminal legal system is not creative at all.) However, the MMRC never looked to the healthcare delivery system, apart from its suggestion of increased clinical monitoring of certain conditions. It refused to engage its creativity to imagine ways to improve the health-compromising environments in which so many women in the state live. *Id.* at 10–11.

[366] *See* VENKATA PS GARIKAPATY, MO. DEP'T OF HEALTH & SENIOR SERVS., PREGNANCY ASSOCIATED MATERNAL MORTALITY REVIEW (PAMR) IN MISSOURI 31 (2015), https://nurturekc.org/wp-content/uploads/2015/01/Missouri-Maternal-Mortality-System.pdf (identifying, among other things, "maternal age" and "smoking during pregnancy" as important factors that have contributed to maternal deaths in the state); YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 14 (criticizing Georgia's MMRC for using "a narrow medical lens" and failing to "consider the impact of social determinants of health on mortality [or] the drivers of the racial disparities in maternal

Notably, the lens through which Louisiana's MMRC views maternal mortality transformed over time. Ten years after concluding that smoking and obesity were the "principle [sic] modifiable clinical risk indicators,"[367] the commission was willing to look more broadly for modifiable causes of maternal death.[368] This broadened focus led the commission to recommend structural, systemic changes.[369] Indeed, when the commission identified individual behavior as problematic and a likely contributor to maternal deaths, it was *healthcare providers'* behavior—not pregnant women's behavior. Remarkably, the commission concluded that the contributing factors most commonly identified in maternal deaths were "[p]rovider and facility-level factors"—like the failure to adequately assess risk and the failure to implement standardized policies and procedures.[370] Where, earlier, the Louisiana MMRC seemed capable of only viewing maternal deaths through the narrowest of clinical lenses,[371] it now wrote:

> Racial disparities in maternal mortality are complex and multifactorial. Mortality is influenced by a wide range of economic, social, and clinical determinants. In addition to health status prior to pregnancy and consistent access to quality healthcare during pregnancy and throughout the life course, social determinants of health such as racial bias and discrimination, lack of transportation or childcare, poverty, and racism in policies, practices and systems can contribute to adverse outcomes, including maternal death.[372]

The lesson here is that not all MMRCs are created equal. Some will do work that is in the service of undoing the structures that make the United States deadly for pregnant women—especially pregnant black women. Others will not share that same commitment. Accordingly, the work that they do will not be transformative. It may not even be effective. Importantly, there is nothing in the Preventing Maternal

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death"); Ungar, *supra* note 185 ("Virginia published entire reports about cancer, opioid abuse and motor vehicle crashes among moms who died. Minnesota's team recommended more education for pregnant women on seat belt use and guns in the home. Michigan's team urged landlords to make sure pregnant women's homes have smoke detectors.").

367 LA. DEP'T OF HEALTH & HOSPS., *supra* note 217, at 9.

368 *See* KIELTYKA ET AL., *supra* note 227, at 4.

369 *See id.* at 4–5 (recommending, among other things, the "[i]ncorporat[ion of] strategies into quality improvement activities to reduce racial bias and modify policies, practices, and systems to support equity in outcomes" and "[a]ddress[ing] inequities in social determinants of health to improve women's preconception health").

370 *Id.* at 20 (identifying contributing factors present in forty-seven deaths and finding that "[p]rovider and facility-level factors" were present in more deaths than "patient-level" factors).

371 *Cf.* YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 14.

372 KIELTYKA ET AL., *supra* note 227, at 22 (citing Bryant et al., *supra* note 115; Gadson et al., *supra* note 116).

Deaths Act that demands that MMRCs take the former path over the latter.

C. Data Fetishization

As discussed above, the Preventing Maternal Deaths Act commits the federal government to spending twelve million dollars annually for five years to fund state maternal mortality review commissions. Proponents of the Act justified its approach with the claim that we need to improve the data that we have about maternal deaths. Legislators, in effect, asserted that without adequate information about maternal deaths, it would be impossible to prevent deaths in the future.[373] Many affirmed that improving the quality of our data about maternal mortality was a necessary "first step" in bringing our ratios down to levels that are comparable to those of other developed nations.[374] Indeed, the hearing that preceded the passage of the Act was titled "Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S."[375]—underscoring that the chosen way to improve outcomes was through generating "better" information.

Of course, there is truth in this position: If we do not know what is causing the problem, we will not know how to solve the problem. However, there is a compelling argument to be made that we *already* know how to save women. Initiatives to demonstrably improve maternal health outcomes include:

- the implementation of toolkits and safety bundles, which are protocols for managing specific emergent events, like hemorrhage, hypertension, and blood clots;[376]

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373 *See, e.g.*, 164 CONG. REC. H10,060 (daily ed. Dec. 11, 2018) (statement of Rep. Burgess) ("This is a problem we cannot address without accurate data."); *id.* (statement of Rep. Green) ("[I]n order to reverse this unconscionable trend, we must have the necessary data so providers can monitor their practices and improve their care delivery.").

374 Chuck, *supra* note 258 ("'This is an amazing first step,' said Dr. Lisa Hollier, president of the American College of Obstetricians and Gynecologists. 'Having high-quality data that is comparable across jurisdictions is going to be so very valuable to our prevention efforts.'").

375 *Hearing on H.R. 1318*, *supra* note 264, at 1 (2018).

376 *See* Ozimek & Kilpatrick, *supra* note 28, at 182 (discussing California's implementation of initiatives to combat maternal mortality). California recently lowered its ratios of maternal mortality by implementing safety bundles at hospitals. *See* Tanya H. Lee, *How California Reduced Its Maternal Deaths: A Q&A with Dr. Elliott Main*, REWIRE.NEWS (Nov. 30, 2017, 3:50 PM), https://rewire.news/article/2017/11/30/maternal-deaths-qa-elliott-main. After hospitals across the state implemented these safety bundles, California became one of the safest places to be pregnant and give birth. *See* Laura Ungar & Caroline Simon, *Which States Have the Worst Maternal Mortality?*, USA TODAY (Nov. 1, 2018, 2:26 PM), https://www.usatoday.com/list/news/investigations/maternal-mortality-by-state/7b6a2a48-0b79-40c2-a44d-8111879a8336/?block=California (ranking California safest out of all states analyzed).

- requiring providers to use checklists, which help to ensure the same quality of care for every patient;[377]
- engaging in simulation trainings in hospitals, which can improve providers' skills and knowledge when responding to a severe pregnancy complication;[378] and
- the "[i]mplementation of a disparities dashboard, which stratifies quality metrics by race and ethnicity" and "allows hospitals and healthcare systems to become aware of disparities within their hospitals and to monitor their performance on quality metrics for groups with higher risks of poor outcomes."[379]

Additionally, it is well-established that doula support during pregnancy and childbirth improves maternal outcomes.[380] In Minnesota, which is one of four states that currently covers doula services through its Medicaid program,[381] Medicaid beneficiaries with doula support were fifty-six percent less likely to give birth via a cesarean section[382]—a procedure that is both a risk factor for, and an effect of, pregnancy complications.[383] Because of the demonstrated

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377 Kavita Shah Arora, Larry E. Shields, William A. Grobman, Mary E. D'Alton, Justin R. Lappen & Brian M. Mercer, *Triggers, Bundles, Protocols, and Checklists–What Every Maternal Care Provider Needs to Know*, 214 AM. J. OBSTETRICS & GYNECOLOGY 444, 447–48 (2016) (discussing support both within and outside of obstetrics for checklists). *See* Howell & Zeitlin, *supra* note 167, at 270 (mentioning checklists as part of a series of recommended practices).

378 Howell & Zeitlin, *supra* note 167, at 270 (referring specifically to simulations training health care providers to respond to shoulder dystocia, a severe childbirth complication).

379 *Id.*

380 Kenneth J. Gruber, Susan H. Cupito & Christina F. Dobson, *Impact of Doulas on Healthy Birth Outcomes*, 22 J. PERINATAL EDUC. 49, 49–50, 54–56 (2013) (reviewing various findings of doulas' positive effects on women's experiences and discussing data showing better outcomes with doulas than without).

381 Those states are Indiana, Minnesota, Oregon, and New York. Note, however, that Indiana's program has yet to be funded, and New York's is a pilot program limited to a few counties. Christina Gebel & Sara Hodin, *Expanding Access to Doula Care: State of the Union*, MATERNAL HEALTH TASK FORCE (Jan. 8, 2020), https://www.mhtf.org/2020/01/08/expanding-access-to-doula-care. *See also* Corrinne Hess, *Milwaukee Plans to Provide Doulas to 100 Women*, WIS. PUB. RADIO (Mar. 20, 2019, 6:00 AM), https://www.wpr.org/milwaukee-plans-provide-doulas-100-women (explaining that Wisconsin's governor has proposed covering doula services through Medicaid); Mattie Quinn, *To Reduce Fatal Pregnancies, Some States Look to Doulas*, GOVERNING (Dec. 21, 2018), https://www.governing.com/topics/health-human-services/gov-doula-medicaid-new-york-2019-pregnant.html.

382 Quinn, *supra* note 381.

383 As noted in Section I.A.2, women who undergo cesarean sections are at greater risk of developing severe, life-threatening complications—caused by the cesarean section itself or the condition that made the cesarean section medically indicated. Moaddab et al., *supra* note 40, at 710 (noting that the correlation between cesarean delivery and maternal mortality is largely due to the indication for cesarean delivery); *see also* Stephanie A. Leonard, Elliott K. Main & Suzan L. Carmichael, *The Contribution of Maternal*

effectiveness of doula support in improving maternal outcomes, the State of New York elected to introduce a pilot program for covering these services through the state's Medicaid program.[384] Scholars have noted that providing Medicaid coverage of doula services could function to ameliorate the impact of the closure of obstetrics units in hospitals that serve high numbers of low-income patients—a phenomenon that both threatens the health of pregnant low-income women and has become more pronounced due to the low reimbursement rates that Medicaid offers for obstetrics care.[385] As one scholar argues in the context of hospitals in Washington, D.C., "Medicaid coverage of doulas would also function to alleviate the impact of reduced access to hospitalized prenatal care by creating an alternative to hospital care."[386] The Preventing Maternal Deaths Act might have provided funds to states to adequately and generously cover doula support through their Medicaid programs.[387] The architects of the Act elected not to make this concrete, effective intervention.

In the face of all that we already know about why pregnant and recently postpartum women are dying—and in the face of all of the knowledge that we already have accumulated about the concrete practices and policies that help women survive pregnancy and childbirth—

Characteristics and Cesarean Delivery to an Increasing Trend of Severe Maternal Morbidity, 19 BMC PREGNANCY & CHILDBIRTH 1, 2, 5–7 (2019) (finding a strong association between cesarean sections and severe maternal morbidity but noting that cesarean sections did not explain increased severe maternal morbidity).

384 Renee Mehra, Shayna D. Cunningham, Jessica B. Lewis, Jordan L. Thomas & Jeannette R. Ickovics, *Recommendations for the Pilot Expansion of Medicaid Coverage for Doulas in New York State*, 109 AM. J. PUB. HEALTH 217, 217 (2019) (noting that, in 2018, the governor of New York, Andrew M. Cuomo, "announced a comprehensive initiative to address maternal mortality and racial disparities in health outcomes" and that the "plan includes increasing access to prenatal and perinatal care through a pilot expansion of Medicaid coverage for doulas").

385 *See* Wilson, *supra* note 128, at 222–23, 226, 229–30, 233–34 (discussing the impact on low-income communities of the closure of, and limited access to, obstetrics units in Washington, D.C.).

386 *Id.* at 234.

387 While Oregon and Minnesota cover doula services through the states' Medicaid programs, observers contend that they cover these valuable services at insufficient rates: "Oregon reimburses doulas $350 per mother for four maternity support visits and the day of delivery. Minnesota reimburses doulas $411 per mother for seven visits, one of which is for labor and delivery." Mehra et al., *supra* note 384, at 217. Analysts argue that the low levels of these rates explain why doula care remains inaccessible to many low-income women: The rates are below the costs to doulas of providing the services to women, and low-income women cannot afford to supplement the reimbursements that doulas receive from Medicaid with their own funds. *See id.* (noting that out-of-pocket fees for doulas in New York City can be between $400 and $2000). Advocates in Minnesota wanted the state to raise the reimbursement rates from $411 to $770. *See* Quinn, *supra* note 381. Although legislators included raised rates in the budget, the governor at the time vetoed the bill. *See id.*

the Preventing Maternal Deaths Act does no more than fund state MMRCs. The Act may be read as pretending that the causes of maternal deaths are an utter mystery. In this way, the Act is not a commitment. It is a pretension. One need not be overly pessimistic to believe that, in the absence of a clear, full-throated commitment to saving the lives of women—especially, black women—the Act will fail to lead to a meaningful reduction in the frequency of maternal deaths, let alone the elimination of racial disparities in maternal mortality.

Further, there is an abundance of evidence demonstrating that the mere existence of a state MMRC that reviews every maternal death in a state is no guarantor of safe pregnancies and childbirths for women. The clearest indication of this is the fact that *nearly every state currently has an MMRC*.[388] Nevertheless, the maternal death ratios in the United States remain the highest in the industrialized world. Indeed, some of the states with the highest maternal death ratios—including Maryland, Michigan, Louisiana, and New York—have MMRCs.[389] Again, the mere existence of these committees has not managed to save women. The commitment to review each maternal death has to be wedded to a commitment to actually implement the policies and practices that have been proven to save lives.[390] Nevertheless, the Preventing Maternal Deaths Act does no more than to fund MMRCs.

This critique should not be read as arguing that information is bad. Rather, the critique here is that if there is a limited pot of money, and that money can either be spent gathering information about a problem or making concrete interventions that are known to be effective ways to address the problem, it is a fascinating political choice to pursue the former over the latter.

We might compare the Act's attempt to address maternal mortality with New York City's effort to address the same. In July 2018, the city announced that it would be dedicating $12.8 million over the course of three years to reduce the frequency of maternal deaths and severe maternal morbidity in the city—specifically, and explicitly,

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[388] *See* Ungar, *supra* note 185 (noting that only seven states—Arkansas, Idaho, Montana, Nevada, Rhode Island, South Dakota, and Wyoming—do not have an MMRC).

[389] *See* AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 104 app. A.

[390] *See* BLACK MAMAS MATTER, *supra* note 40, at 63 ("Gathering the information is *only* step one. We must also demand that this nation make the needless loss of women, especially black women, a priority that the community invests in together to eliminate[, said] Dr. Joia Crear-Perry, Founder of National Birth Equity Collaborative.") (emphasis added); YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 60 ("[I]solated collection of data . . . alone will not alleviate systemic barriers around access to and quality of care.").

among women of color.[391] In dramatic contrast to the Preventing Maternal Death Act's single-pronged approach to saving lives through information gathering, New York City's approach is multifaceted. Certainly, the city acknowledges the need to improve data about maternal deaths: A component of the plan focuses on the city's existing MMRC, charging the committee to review cases of severe maternal morbidity in addition to cases of maternal deaths.[392] Additionally, the plan endeavors to remedy the problem of the years-long delay in the release of annual data, providing that the Health Department will release preliminary estimates of mortality events every year.[393] However, unlike the Preventing Maternal Deaths Act, New York City's effort goes well beyond the mode of information-as-intervention. The plan provides that:

- hospitals will engage in "simulation training" in which staff must identify and respond to emergent obstetric events, specifically postpartum bleeding and blood clots;[394]
- the city will enlist "maternal care coordinators" to ensure that "high-risk" patients, among other things, keep their appointments and are able to access the medications that providers prescribe to them;
- women will receive healthcare *before* they become pregnant, and providers will assess them for their risk of developing complications should they become pregnant;[395] and
- women will have access to a variety of programs that will offer them disease management or doula support, including a "Nurse-Family Partnership program," a "Newborn Home Visiting Program," and "the By My Side program, which provides doula support services."[396]

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391 *See De Blasio Administration Launches Comprehensive Plan to Reduce Maternal Deaths and Life-Threatening Complications from Childbirth Among Women of Color*, NYC (July 20, 2018), https://www1.nyc.gov/office-of-the-mayor/news/365-18/de-blasio-administration-launches-comprehensive-plan-reduce-maternal-deaths-life-threatening ("The five-year plan aims to eliminate disparities in maternal mortality between Black and White women—where the widest disparity exists . . . .").

392 *See id.* (providing that the plan will "support[ ] private and public hospitals to enhance data tracking and analysis of severe maternal mortality and maternal morbidity events").

393 *See id.*

394 The plan focuses on these two events because they are "the two top causes of pregnancy-related deaths for women of color." *Id.*

395 *Id.* (stating that the plan includes the "hir[ing] of maternal care coordinators to assist an estimated 2,000 high-risk women in the prenatal and postpartum periods to keep appointments, procure prescriptions, and connect women to eligible benefits").

396 *Id.*

Simply put, New York City does not fetishize data. The city's plan to address maternal mortality does not pretend that information alone will prevent deaths. It links the necessity of gathering data on maternal mortality and morbidity with concrete initiatives that history has shown to improve maternal outcomes.

There is a danger that with the passage of the Preventing Maternal Deaths Act, the country will rest on its laurels—satisfied that it has done *something* about the problem of maternal mortality in the United States. That is, there is a danger that the creation of state MMRCs and the collection of data on maternal deaths will be taken to be an end in itself—as opposed to a means to the ultimate end of reducing the frequency of maternal deaths in the country. It is imperative to underscore that *data will not save women*. Information about why women are dying—without a political and financial commitment to intervene in the complex processes that make pregnancy and childbirth deadly events in the United States—will not make pregnancy and childbirth any safer for women, especially black women, in the United States.[397]

CONCLUSION

The foregoing discussion leaves us with a question: Is *something* sometimes worse than *nothing*? The Preventing Maternal Deaths Act presents the puzzle of whether black women might actually be worse off after the Act's passage. If there is a modicum of truth in the preceding analysis, the Act will fail to address black women's needs. It ignores the reality that black women are more frequently felled on the path to motherhood, refuses to charge state MMRCs with the task of investigating the large-scale, macro processes that make the United States a dangerous place for women (and black women, specifically) to be pregnant and give birth, and pretends that more and better data

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397 *See, e.g.*, REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 55 (noting that "[s]tate- and local-level MMRCs are poised to be the gold standard for understanding why maternal deaths continue to occur and make recommendations for action," but stating that they must "connect MMRC data to action").

Similarly to how the Preventing Maternal Deaths Act pretends that the problem of maternal mortality is a problem of information, politicians have only been willing to "study" the possibility of reparations. *See* Sheryl Gay Stolberg, *House Democrats, with Pelosi's Support, Will Consider a Commission on Reparations*, N.Y. TIMES (June 18, 2019) (discussing a "House bill, titled the 'Commission to Study and Develop Reparation Proposals for African-Americans Act,'" that would fund a commission that "would study the effects of slavery and racial discrimination, hold hearings across the country and recommend 'appropriate remedies' to Congress"). In the contexts of both maternal mortality and reparations, there is a lack of a political will to make actual material interventions that will produce change. Politicians have been able to punt on both issues by framing them as ones about which we just need more data.

(as opposed to concrete interventions) will save pregnant women and new mothers. While being woefully unresponsive to the actual, material needs of black women, the Act may take up the political, legal, and cultural space for more effective, responsive interventions—leaving black women in a worse position than they were before.

Time will tell whether black women are actually served by Congress's colorblind foray into a problem that race and racism have produced.

COMMENTARY RACE

How False Narratives of Margaret Sanger Are Being Used to Shame Black Women

Aug 20, 2015, 12:08pm Imani Gandy

Anti-choicers wield misattributed and often outright false quotes about Sanger as weapons to shame Black women for exercising their right to choose, and even more nonsensically, to shame them for supporting Planned Parenthood.

In the wake of the attacks by the Center for Medical Progress, Planned Parenthood's origins and its founder, Margaret Sanger, have once again become the center of conversations regarding Black women and abortion. And since anti-choice fanatics seem utterly incapable of making an honest argument in support of their position that Black women should be forced into childbirth rather than permitted to make their own decisions about what to do with their bodies, they resort to lies, misinformation, and half-truths about Sanger and the organization she founded.

Anti-choicers wield misattributed and often outright false quotes about Sanger as weapons to shame Black women for exercising their right to choose, and even more nonsensically, to shame them for supporting Planned Parenthood.

"Margaret Sanger was a racist and a eugenicist! She wanted to exterminate the Black race!" Such is the clarion call of these anti-choicers.

At the outset, I'd be remiss if I didn't point out that whether or not Planned Parenthood had its roots in anti-Blackness is irrelevant in a discussion of the services that Planned

Parenthood provides in 2015, ranging from abortion care to prevention and treatment of sexually transmitted infections, to Pap smears and other forms of cancer screening. The United States is rooted in anti-Blackness. Anti-Blackness was built into the U.S. Constitution by this country's Founding Fathers. Nearly every major corporation that exists today was either founded by racists, employed racists, built their business on anti-Blackness and slavery, or all of the above. Any argument that Black women in America should disavow Planned Parenthood because of some history of anti-Blackness would necessarily require that Black women disavow the very country in which we live.

Anti-choicers wield misattributed and often outright false quotes abou for exercising their right to choose, and even more nonsensically, to s Parenthood.

Bio / YouTube

But on to the truth about Margaret Sanger.

Sanger was pro-birth control and anti-abortion. This may surprise you, considering that Planned Parenthood opponents frequently accuse Sanger of erecting abortion clinics in Black neighborhoods, a practice they claim the organization continues to this day.

But this is simply not true.

Sanger opposed abortion. She believed it to be a barbaric practice. In her own words, "[a]lthough abortion may be resorted to in order to save the life of the mother, the practice of it merely for limitation of offspring is dangerous and vicious." Her views are, ironically, in keeping with the views of many of the anti-choicers who malign and distort her legacy.

In fact, Planned Parenthood did not even begin performing abortions until after 1973, when the U.S. Supreme Court's decision in *Roe v. Wade* legalized the practice. Margaret Sanger had been dead for four years by then. And currently, less than 4 percent of Planned Parenthood clinics that offer abortion services are located in communities where more than one-third of the population is Black, according to a recent analysis conducted by Planned Parenthood that Alencia Johnson, assistant director of constituency communications at Planned Parenthood, shared with me via email. A broader analysis conducted by the Guttmacher Institute in 2011 based on data available from the Centers for Disease Control and Prevention shows that fewer than one in ten abortion providers overall are located in neighborhoods where more than half of residents are Black. It is simply false that Planned Parenthood is targeting Black women by setting up clinics primarily in Black neighborhoods.

It is true that Sanger was a proponent of eugenics, and pro-choice advocates do themselves no favors by attempting to whitewash this fact and paint Sanger as some infallible feminist hero. Sanger was passionate about contraception—perhaps to a fault—and her fervor about promoting her birth control agenda led her to align herself with eugenicists, along with racists and an assortment of people of questionable character.

But it is simply untrue that Margaret Sanger wanted to exterminate the Black race. This is a flat-out lie. Yet it is one that is repeated ad nauseum, both by anti-choice activists and the politicians who support them, most recently Ben Carson.

In propagating this lie, anti-choicers infantilize Black women and strip them of their agency: They portray Margaret Sanger's birth control agenda as something that was done

to Black women, rather than something in which Black women and much of the Black community as a whole enthusiastically participated.

The Negro Project

In her seminal book *Killing the Black Body*, Dorothy Roberts points out that leaders in the Black community actually welcomed Sanger's birth control agenda in the 1930s, and even criticized it for not going far enough to serve Black people.

W. E. B. Du Bois, who was one of the first Black leaders to publicly support birth control and who worked closely with Sanger to advocate for it, even serving on the board of a clinic that Sanger opened up in Harlem, criticized the wider birth control movement because of its failure to address Black people's needs as well.

It was this failure that gave birth to the sinister-sounding Negro Project.

Due to segregation policies in the South, the birth control clinics that opened in the 1930s were for white women only. Sanger wanted to change that. She sought to open clinics in the South staffed by Black doctors and nurses, and to educate Black women about contraception. In 1939, after she had been named honorary chairman of the board of Birth Control Federation of America (the precursor to Planned Parenthood), Sanger launched the Negro Project. The Federation's Division of Negro Services, a national advisory council, which included prominent Black leaders like Du Bois, Mary McLeod Bethune, E. Franklin Frazier, Walter White, and Rev. Adam Clayton Powell, worked to manage the Negro Project.

The Negro Project had nothing to do with some nefarious plot to exterminate Black people or to "sterilize unknowing Black women," as claimed by BlackGenocide.org—which is a widely read website seemingly dedicated to spreading false information about Margaret Sanger and Planned Parenthood. Rather, the Negro Project was a concerted effort by Sanger and Black community leaders to bring birth control to the South in a way that would assuage the deep-seated fears of Black birth control opponents like Marcus Garvey, who believed that the use of birth control in the Black community was tantamount to Black genocide.

Many opponents of Planned Parenthood purposefully obfuscate this history in order to paint Sanger, and in turn Planned Parenthood itself, as spearheading a plot to kill off Black people. Anti-choice fanatics typically rely on two quotes as their bread and butter in this

claim, even as they use Black women as weapons in their war against abortion. It's high time to set the record straight.

The first is a Sanger quote in which she defends the Negro Project in seemingly racist language: "The mass of Negroes particularly in the South still breed carelessly."

The second quote can be found in Sanger's infamous letter to Clarence J. Gamble: "We do not want word to go out that we want to exterminate the Negro population."

The first quote, even when read in full and in context, certainly sounds damning:

> The mass of Negroes particularly in the South still breed carelessly and disastrously, with the result that the increase among Negroes, even more than among whites, is from that portion of the population least intelligent and fit, and least able to rear children possibly.

But what anti-choicers either don't know or willfully obscure is that Sanger borrowed this quote directly from W. E. B. Du Bois.

Du Bois was a passionate advocate of civil rights and a defender of Black women, specifically. He also publicly supported birth control. Nevertheless, as Dorothy Roberts wrote, "Du Bois and other prominent Blacks were not immune from the elitist thinking of their time. As reflected in Du Bois's statement borrowed by Sanger to promote the Negro Project, they sometimes advocated birth control for poorer segments of their own race in terms painfully similar to eugenic rhetoric."

Does the fact that Sanger borrowed the quote from Du Bois excuse her actions? Maybe. Maybe not. But it certainly provides some much-needed context.

The second quote, "We do not want word to go out that we want to exterminate the Negro population," might be Planned Parenthood opponents' favorite. It is culled from a 1939 letter to Dr. Clarence J. Gamble, heir to the Proctor & Gamble fortune, and is even more damning than the borrowed Du Bois quote—if you ignore the context in which it was written, that is.

That context wasn't about hiding the "true exterminatory purpose" of the Negro Project from Black people. Rather, it was about elucidating the true purpose of the project—

disseminating birth control in Black communities in the South—and training Black doctors to work within their own communities:

> It seems to me from my experience where I have been in North Carolina, Georgia, Tennessee and Texas, that while the colored Negroes have great respect for white doctors they can get closer to their own members and more or less lay their cards on the table which means their ignorance, superstitions and doubts. They do not do this with the white people and if we can train the Negro doctor at the Clinic he can go among them with enthusiasm and with knowledge, which, I believe, will have far-reaching results among the colored people. His work in my opinion should be entirely with the Negro profession and the nurses, hospital, social workers, as well as the County's white doctors. His success will depend upon his personality and his training by us.
>
> The minister's work is also important and also he should be trained, perhaps by the Federation as to our ideals and the goal that we hope to reach. We do not want word to go out that we want to exterminate the Negro population and the minister is the man who can straighten out that idea if it ever occurs to any of their more rebellious members.

A related memo written by Dr. Gamble in 1939 clarifies the point:

> There is great danger that we [the Negro Project] will fail because the Negroes think it a plan for extermination. Hence let's appear to let the colored run it.

Sanger's full quote in context has the exact opposite meaning that anti-choicers like to attribute to it.

Moreover, Sanger also held some rather forward-thinking views about the oppression of Black people, especially for a white feminist in the early 20th century. In an oft-ignored interview with Earl Conrad for the *Chicago Defender* in 1945, Sanger said:

> Discrimination is a world-wide thing. It has to be opposed everywhere. That is why I feel the Negro's plight here is linked with that of the oppressed around the globe.

> The big answer, as I see it, is the education of the white man. The white man is the problem. It is the same as with the Nazis. We must change the white attitudes. That is where it lies.

In that same article, Sanger described an encounter with an "anti-Negro white man":

> When we first started out an anti-Negro white man offered me $10,000 if I started in Harlem first. His idea was simply to cut down the number of Negroes. 'Spread it as far as you can among them,' he said. That is, of course, not our idea. I turned him down. But that is an example of how vicious some people can be about this thing.

Not exactly the words of a woman hell-bent on exterminating Black people, are they?

It is undeniable that Sanger espoused some problematic and racist views about Black people. Certainly her paternalistic attitudes about Black people's ability to disseminate information about birth control in their own community—along with Sanger's view that, as Dorothy Roberts wrote, "many Blacks were too ignorant and superstitious to use contraceptives on their own"—were indubitably racist. And although you'd be hard-pressed to find any white person at the time who was completely free of racist thinking, and some of her problematic views echoed the views of prominent Black leaders, that still doesn't absolve her.

But as Jay Smooth pointed out in his viral video How to Tell Someone They Sound Racist, there's a difference between being a racist and making racist remarks. Margaret Sanger, without question, made a lot of racist remarks. But was she a capital-R racist? I don't think so, and that's a question on which the answer scholars like Dorothy Roberts, Linda Gordon, Carole McCann, and others have been unable to agree.

The truth about Sanger and her birth control crusade is far more complex, and requires a nuanced discussion of the type that your average anti-choice crusader is either incapable or unwilling to engage.

Sanger and Eugenics

Margaret Sanger held many abhorrent ideas about population control and eugenics, ideas that any decent person today would find horrifying.

Yes, she believed that the "reckless breeding" of the "feebleminded" was "the greatest biological menace to the future of civilization." Yes, she believed that Americans were "paying for and even submitting to the dictates of an ever-increasing, unceasingly spawning class of human beings who never should have been born at all." Yes she believed that "morons" should be forcibly sterilized to ensure that they could not breed. She also believed that these "morons" could not be trusted to properly use birth control. Frankly, Sanger was far more ableist than she was racist.

But she was also a product of her time. The terms "moron," "imbecile," and "idiot" were all medical classifications back then. And eugenics—the theory that intelligence and other traits are genetically predetermined—was very popular at the turn of the century. The concern that "inferior stock" was reproducing at a faster rate than "superior stock," was widespread. Inferior stock included anyone not viewed as a descendant of good breeding: Black people, immigrants, mentally and physically disabled people, the poor, criminals, and the "feebleminded."

This widespread concern gave way to a panic about "race suicide," which saw white people fretting about the deterioration of the race as a result of immigrants and Black people outbreeding good upstanding white Anglo-Saxon Americans. (Echoes of this fear exist today: white conservatives are still urging red-blooded patriotic Americans—i.e., white Americans—to breed, dammit, breed and the Quiverfull movement is very popular among Christian extremists.)

So strong was the fear of "race suicide" that even President Theodore Roosevelt attempted to shame white women of "superior stock," also known as wealthy white women, into having more children. In his 1903 State of the Union address, Roosevelt proclaimed that "willful sterility is, from the standpoint of the nation, from the standpoint of the human race, the one sin for which there is no atonement."

The flip side of shaming wealthy white women into reproducing more quickly was figuring out a way to keep the "inferior stock" from breeding, so that healthy and wealthy white women could catch up and forestall the deterioration of the race. The answer to that quandary was forced sterilization on a massive nationwide scale in order to keep "undesirable" people from procreating.

The principle targets of the programs included not only women of color (primarily Southern Black women, although California's sterilization program targeted many Latina

women), but also criminals, the poor, and any women—including white women—who were believed to be "feebleminded," with feeblemindedness often corresponding to sexual promiscuity.

All of this is to say that concerns about population control weighed heavy on the minds of Americans in the early 20th century. Classes on eugenics were taught in colleges nationwide; eugenics was presented as scientific fact in biology textbooks; and the American Eugenics Society held "Fitter Families Contests" at state fairs throughout the 1920s, during which rural American families were encouraged to compete with one another to determine which family had the best "human stock." Medals that read "Yea, I have a goodly heritage" were awarded to families that were deemed genetically favorable.

It may seem bizarre and Orwellian to us now, but that was the United States in which Sanger lived. And given the enthusiasm with which ordinary Americans embraced eugenics, it is no surprise that Sanger eventually joined up with them.

Sanger didn't begin her campaign for birth control as a eugenicist, though. She started out as a relatively hardcore feminist. She believed that women had the right to sexual gratification and the right to choose when to become mothers.

"No woman can call herself free who does not own and control her own body. No woman can call herself free until she can choose consciously whether she will or will not be a mother." Those are Sanger's own words.

But feminists at the time disapproved of Sanger's insistence on women's rights to sexual gratification. They largely believed that Sanger's views were unchaste and immoral, and that a woman's place was in the home, serving her husband and being virtuous. (Not unlike many anti-choicers today who believe that if you are unwilling to deal with an unplanned pregnancy, or as they like to call it "the consequences of sex," then you should just abstain—forever, if necessary.)

And because Margaret Sanger was passionately committed to her birth control crusade, her fervor led her away from feminism and toward an allyship with racists and eugenicists. This included, as this favored anti-choice meme suggests, giving a speech at a KKK rally in Silver Lake, New Jersey, in 1926.

But before you recoil in abject horror, remember that the KKK was a powerful political movement at the time—five U.S. presidents were members of the KKK at one point or

another—and if Sanger could convince the ladies of the KKK of the benefits of birth control, then it was worth it to her. That certainly doesn't excuse her turning to this country's most notorious domestic terrorist group for support (and personally, I find it deplorable) but there was no one whom Sanger wouldn't talk to about birth control.

Certainly, many of the prominent eugenicists with whom Sanger worked were virulently racist. Their attraction to birth control was that it would lead to "racial betterment" if promoted in immigrant and Black communities, and Sanger was OK with that.

Sanger herself promoted birth control as a way to reduce the birth rate of undesirable classes—"morons" and such—but the fact that many eugenicists viewed Black people as an undesirable class didn't seem to bother her. In other words, so long as eugenicists continued to disseminate information about birth control, she didn't appear to care about their reasons for doing so. (Notably, many prominent eugenicists at the time didn't believe that *all* Black people were unfit, but rather they believed in "selective migration"—that the intelligent and desirable Black people tended to migrate to the North, leaving the less intelligent Black people behind.)

Some scholars have called her allyship a savvy political move. It enabled her to couch her birth control agenda in terms that the "race suicide" fearmongerers could understand. Other scholars view it as racist.

Whether or not she was a capital-R racist is ultimately of little concern, because as Dorothy Roberts points out, her allyship with eugenicists facilitated the goals of eugenicists, and that is something that the reproductive rights community should never gloss over:

> It appears that Sanger was motivated by a genuine concern to improve the health of the poor mothers she served rather than a desire to eliminate their stock. Sanger believed that all their afflictions arose from their unrestrained fertility, not their genes or racial heritage … Sanger nevertheless promoted two of the most perverse tenets of eugenic thinking: that social problems are caused by reproduction of the socially disadvantaged and that their childbearing should therefore be deterred. In a society marked by racial hierarchy, these principles inevitably produced policies designed to reduce Black women's fertility.

Alas, such nuanced arguments are not suitable for the 140-character soundbite world in which the abortion wars are currently being waged.

Ultimately, Margaret Sanger was a complicated woman living in a complicated time.

But to hear anti-choice zealots tell it, she was the American version of Hitler, proposing a "final solution" to the "Black question." This is nonsense.

Anti-choicers also like to claim that Sanger was closely associated with the eugenics program in Nazi Germany. While she may be loosely associated with the program, in the same way that every American who promoted eugenics was loosely associated with the Nazis, the Nazis specifically modeled their eugenics laws on California's sterilization law, not on Sanger's beliefs or writings. The United States, after all, led the world in compulsory sterilization until Hitler took up the practice.

In 1927, the United States Supreme Court ruled that Virginia's compulsory sterilization law was constitutional in *Buck v. Bell*, a stunningly awful decision in which Justice Oliver Wendell Holmes proclaimed "[t]hree generations of imbeciles are enough." That decision set the stage for state after state to enact compulsory sterilization laws. By the time the Nazis embarked on their eugenics program, more than 30 states had such laws on their books. It wasn't Sanger personally who influenced the Nazis. It was the United States as a whole.

In fact, the Nazis were not fans of Sanger. They even burned her books, as Gerald V. O'Brien points out in his article, "Margaret Sanger and the Nazis: How Many Degrees of Separation." Moreover, as Amita Kelly writing for NPR recently pointed out, "Sanger herself wrote in 1939 that she had joined the Anti-Nazi Committee 'and gave money, my name and any influence I had with writers and others, to combat Hitler's rise to power in Germany.'"

Undoubtedly, Sanger held a lot of beliefs that are repugnant to us now.

But that doesn't mean supporters of Planned Parenthood and abortion rights activists shouldn't push back on the abject falsehoods that anti-choicers spread about Planned Parenthood and its founder while at the same time reckoning with Sanger's more deplorable beliefs.

We can do both. We *must* do both.

> **CORRECTION:** The article has been updated to clarify the number of years between Margaret Sanger's death and when the first Planned Parenthood

had begun offering abortions.

TOPICS AND TAGS: Abortion, Access to contraception, Birth Control, Black Women, Contraception, Contraception, Eugenics, Family, Family planning clinics, Hormonal contraception, Human Rights, KKK, Margaret Sanger, Nazis, Planned Parenthood, race and abortion, Reproductive rights, Roe vs. Wade, Sexual Health, Sexuality education, Women's rights

RELATED ARTICLES

November 18, 2021

Chairman Jerrold Nadler
U.S. House Judiciary Committee
2138 Rayburn House Office Building
Washington, D.C. 20515

Ranking Member Jim Jordan
2138 Rayburn House Office Building
Washington, D.C. 20515

RE: Letter for the Record for House Judiciary Committee's Hearing, "The Texas Abortion Ban and Its Devastating Impact on Communities and Families."

Dear Chairman Nadler, Ranking Member Jordan, and Members of the Committee:

The National Asian Pacific American Women's Forum (NAPAWF) submits this letter for the record for the House Judiciary Committee's November 4, 2021 hearing, "The Texas Abortion Ban and Its Devastating Impact on Communities and Families."

NAPAWF is the only national organization dedicated to building power with Asian American and Pacific Islander (AAPI) women and girls and is mobilizing the AAPI community in Texas to fight back against abortion restrictions. NAPAWF gives voice to issues central to AAPI women and girls and is fighting to make sure AAPI women have access to reproductive health care, including abortion.

S.B. 8 is Devastating for AAPI Women

As long as Texas Senate Bill (S.B.) 8 remains in effect, it will further isolate low-income and immigrant AAPIs by making abortion care unaffordable and out of reach, compounded by existing economic and legal barriers.

S.B. 8 disproportionately impacts low-income persons, immigrants, and people of color in Texas, which is the third most populated AAPI state after California and New York. Out of the 1.53 million AAPIs in Texas, a staggering 17 percent are estimated to be without immigration status, 12 percent lack health insurance, and 11 percent live in poverty.

With COVID-19, the economic status of AAPI women is even grimmer. While AAPI women have historically been overrepresented in front-line and low-wage jobs that prevent them from accessing health care, many who lost their jobs as a result of COVID-19 have also lost health coverage. Of those who lost their jobs during the pandemic, almost half of them have been out of work for longer than six months, adding greater economic pressure to AAPI women.

For AAPI women who rely on Medicaid for health care, they often find themselves unable to afford an abortion. In 2019, nearly 16 percent of non-elderly AAPI women relied on Medicaid, with this program being particularly crucial for South and Southeast Asian women. However, federal funds cannot be used to pay for abortion care (apart from rape, incest, or if a pregnant person's life is in danger), banning Medicaid and other health programs from using federal funds for abortion.

While 8 out of 10 AAPI women consider having control over their own bodies as a key issue, they face numerous barriers that hinder their access to abortion. For AAPI Texans, SB 8 exacerbated existing difficulties, making it nearly impossible for them to obtain an abortion in their own state. Currently, Texans who are able to afford it are driving hundreds of miles for out-of-state abortion care, including to at least 12 states that do not border Texas. For immigrants who are traveling to seek an abortion, the stakes are even higher as they travel through Immigration and Customs Enforcement checkpoints without status or documentation.

When women are denied an abortion, they are more likely to fall into poverty than a woman who can obtain one. At the same time, when a woman is able to get an abortion, her children are more likely to achieve developmental milestones and live in a household above the poverty line than compared to the children of women who were denied abortions. S.B. 8 severely curtails AAPI women's ability to exercise control over their own lives.

S.B. 8 Implicates Other Civil Liberties and Gives Permission to Other States to Ban Abortion

S.B. 8 is harmful not only due to its almost complete ban of abortion but also because it implicates other crucial civil liberties such as the right to contraceptives and provides a roadmap for other states attempting to ban abortion, many of which have significant AAPI populations.

We thank the Committee for looking into this crucial issue for AAPIs. If you have any questions, please contact Da Hae Kim at dkim@napawf.org.

Sincerely,

Yvonne Hsu, Chief Policy and Government Affairs Officer

Statement of NARAL Pro-Choice America
U.S. House Committee on the Judiciary
The Texas Abortion Ban and its Devastating Impact on Communities and Families
November 4, 2021

Thank you for the opportunity to submit a statement to the U.S. House Committee on the Judiciary on the vital topic of Texas's unconstitutional abortion ban, Senate Bill 8 (SB 8), and its devestating impact on communities and families in Texas and around the country. NARAL Pro-Choice America (NARAL) is a national advocacy organization, dedicated to protecting and advancing reproductive freedom, including access to abortion, contraception, paid leave, and protection from pregnancy discrimination, as a fundamental right and value. Through education, organizing, and influencing public policy, NARAL and our 2.5 million members from every state and congressional district in the country work to guarantee every individual the freedom to make personal decisions about their lives, bodies, and futures, free from political interference. For this reason, we are submitting this statement to reiterate the harm state-level attacks on abortion have on reproductive freedom.

The right to abortion faces its greatest threat in decades. Despite overwhelming public support (8 in 10 Americans) for the legal right to abortion, we're in the midst of an all-out assault on reproductive freedom with *Roe v. Wade* hanging in the balance. Anti-choice lawmakers are emboldened in their attack on reproductive freedom by a decades-long strategy to capture the courts, resulting in an anti-choice supermajority on the Supreme Court. This year alone, state legislatures have introduced, advanced, or passed over 330 abortion restrictions, systematically chipping away at the right to abortion across the country and pushing access to abortion care out of reach for millions of people. We are now witnessing the effects of the anti-choice supermajority, who were put on the Supreme Court for an explicit purpose: to undermine legal abortion, access to contraception, and reproductive freedom more broadly as they advance an agenda of power and control.

On September 1st, the most restrictive and draconian abortion ban, Texas SB 8, went into effect in Texas, bannning abortion before most people know they are pregnant and creating a bounty hunter system for private citizens to enforce the law with an incentive of a $10,000 reward. The Supreme Court failed to intervene and subsequently rejected an emergency request to block SB 8, a blatantly unconstitutional ban on abortion. This law bans abortion at approximately six weeks—before many people even know they are pregnant. It also grants private citizens the power to sue abortion providers and anyone else who helps someone access abortion care; this includes clergy members or counselors, abortion funds that assist someone in paying for abortion care, and even someone who drives a patient to their appointment, like family members, friends, and rideshare drivers. An individual who successfully sues someone for

"aiding and abetting" a pregnant person seeking abortion care, would receive a financial reward of $10,000.

In the nearly two months since the law has been allowed to remain in effect, Texans have already felt the overwhelming burden of trying to access abortion care. Texas patients now have to travel 14 times farther to get an abortion—increasing driving distance from the original average of 17 miles to 247 miles each way.[i] As a result, people in Texas who need to access abortion services must have the resources to travel hundreds of miles out of state, take time off work, and arrange child care and transportation. These costs reflect just one set of barriers; immigration status and checkpoint concerns may also inhibit travel. Based on recent data estimates, only 16% of Texans seeking abortion care are eligible to receive servies under SB 8.[ii] The compounding effects of these barriers mean that many people seeking abortions in Texas will carry their pregnancies to term against their will. The impact of this unconstitutional abortion ban is devastating, overwhelmingly harming Black and Latinx people, people with low incomes, and people in rural areas, who already face steep barriers whento accessing healthcare access.

The Supreme Court's decision to allow SB 8 to go into effect essentially gave Texas the green light to render *Roe v. Wade* meaningless in the state and empowered anti-choice lawmakers to use this law as a blueprint to roll back reproductive freedom in their own states. Politicians in at least 13 states have already expressed intent to introduce similar versions of Texas's abortion ban. In fact, just weeks after Texas's SB8 went into effect, anti-choice lawmakers in Florida introduced their own version of the law, HB 167 and just days ago, Ohio introduced their own version of the law, HB 480, going even further to ban abortion outright.

Earlier this week on November 1st, SB 8 was back at the Supreme Court, as the Court heard oral arguments for cases brought by both the United States Department of Justice and a broad coalition of Texas abortion providers and advocates. These cases are about much more than abortion; everyone who cares about their constitutional rights should be concerned. This kind of vigilante-enforcement scheme could easily be used to ban free speech, marriage equality, or any other right. This all comes just one month before the Supreme Court will consider *Dobbs v. Jackson Women's Health Organization*, a direct threat to *Roe v. Wade* on December 1st, 2021. The threat to the constitutional right to abortion is no longer prospective, it is here.

The looming threat to the future of legal abortion across the country is the result of a decades-long far-right strategy to advance a radical and out-of-touch ideological agenda. In the late 1970s, radical conservatives weaponized the formerly non-political, back-burner issue of abortion rights as political cover for their efforts to maintain white patriarchal control amidst diminishing support for racist policies like school segregation, which had previously been the backbone of their movement. In the years immediately preceding and following *Roe v. Wade*, Evangelical Christians, who now form the backbone of the GOP, were overwhelmingly indifferent on the issue of abortion. But through the carefully crafted messages of Paul Weyrich, Jerry Falwell, and other architects of the Radical Right, abortion became the political

tool of choice for a movement determined to maintain control in a changing world, and the trojan horse for a far-reaching array of ideologies meant to thwart social progress.[iii]

In the intervening years, opposition to abortion has become a litmus test in far-right circles for a host of political and judicial positions. In order to advance their agenda—one that stands in direct opposition to the values of the majority of Americans—they developed and implemented a strategy for capturing and maintaining minority rule. This strategy included pushing regressive boilerplate legislation chipping away at access to abortion through state legislatures and Congress, as well as stacking the federal judiciary with anti-choice ideologues.

Anti-choice activists have spent decades building their influence over the federal judiciary through well-funded, secretive networks like the Federalist Society. Conservative activists have never been shy about the fact that their takeover of the federal judiciary is part of a broad strategy to quell the majority and cement minority rule, but the election of Donald Trump took this tactic to new heights. In May 2016, Trump pledged to only nominate anti-choice judges, a promise he doubled down on in 2020.[iv,v] And with the help of Mitch McConnell, Trump installed anti-choice federal judges with lifetime appointments at a breakneck pace. More than a quarter of currently active federal judges are now Trump appointees, including Supreme Court justices Neil Gorsuch, Brett Kavanaugh, and Amy Coney Barrett—tipping the balance of the Court to a supermajority unmistakably hostile to reproductive freedom.[vi] As Barrett's nomination and confirmation were rushed through in the midst of an ongoing election, many advocates cautioned that this was yet another part of the anti-choice strategy to ultimately overturn *Roe*. Now we have already seen this supermajority on the Court use the so-called "shadow docket" to undermine the right to abortion and abortion access.[vii]

With the Court poised to hear *Dobbs v. Jackson Women's Health Organization*, a case involving a Mississippi 15-week abortion ban that is a direct challenge to *Roe v. Wade,* there is no denying that the threat to the constitutional right to abortion is real. If *Roe* fell tomorrow, 24 states would likely take action to prohibit abortion outright. Twelve states already have "trigger bans" in place, which would ban abortion immediately if *Roe* is overturned.[viii] If the Supreme Court rolls back or overturns *Roe v. Wade* and states are able to outlaw abortion,
there would be devastating consequences for real people. If abortion is banned, how would these bans be enforced? Will people be thrown in jail for having an abortion or miscarriage? What kind of interrogation would somebody be subjected to in order to investigate how a pregnancy ended? Would somebody who had an abortion or experienced a pregnancy loss serve jail time for it? Will doctors and other healthcare providers be jailed if they provide abortion care or assist someone during a miscarriage? Weakening or overturning *Roe* poses a threat to our fundamental rights to make personal decisions beyond abortion, including who to have intimate relationships with, who to marry, and to use contraception.

Anti-choice lawmakers, emboldened by the anti-choice supermajority on the Court, have accelerated their push to pass blatantly unconstitutional bans and restrictions on abortion.

The Supreme Court has further enabled this quest by allowing these laws to take effect causing millions of people suffer the loss of their constitutional right to abortion, evidenced now by the devastating consequenes to Texans' ability to access abortion care. States should not be able to construct loopholes to deny citizens within their borders their constitutional rights. NARAL strongly urges the Committee to consider the harm these state-level attacks on millions of Americans as we work toward a world where *every* body is free to make the best decisions for themselves, their families, and their lives.

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[i] Elizabeth Nash, *Impact of Texas' Abortion Ban: A 14-Fold Increase in Driving Distance to Get an Abortion,* Guttmacher Institute (Sept. 15 2021) https://www.guttmacher.org/article/2021/08/impact-texas-abortion-ban-14-fold-increase-driving-distance-get-abortion.

[ii] Kari White et al, *Texas Senate Bill 8: Medical and Legal Implications,* Texas Policy Evaluation Project (July 2021) https://liberalarts.utexas.edu/txpep/research-briefs/senate-bill-8.php.

[iii] Randall Balmer, *The Real Origins of the Religious Right*, POLITICO MAGAZINE (May 27, 2014), https://www.politico.com/magazine/story/2014/05/religious-right-real-origins-107133.

[iv] *Trump Letter on Pro-Life Coalition*, Sept. 2016, https://www.sba-list.org/wp-content/uploads/2016/09/Trump-Letter-on-ProLife-Coalition.pdf.

[v] *Pro-Life Voices for Trump 2020*, Sept. 3, 2020, https://cdn.donaldjtrump.com/public-files/press_assets/pro-life-letter-potus.pdf.

[vi] John Gramlich, *How Trump compares with other recent presidents in appointing federal judges*, PEW RESEARCH CENTER (Jan. 13, 2021), https://www.pewresearch.org/fact-tank/2021/01/13/how-trump-compares-with-other-recent-presidents-in-appointing-federal-judges/.

[vii] *Whole Woman's Health v. Jackson*, No. 21A24, 2021 WL 3910722 (U.S. Sept. 1, 2021); *Food & Drug Admin. v. American College of Obstetricians & Gynecologists*, 141 S.Ct. 578 (2021).

[viii] Center for Reproductive Rights, *What if Roe Fell?* (Nov. 1, 2021) https://maps.reproductiverights.org/what-if-roe-fell.

Planned Parenthood® Care. No matter what.

Planned Parenthood® Act. No matter what.
Planned Parenthood Action Fund

Statement for the Record from
Planned Parenthood Federation of America and Planned Parenthood Action Fund

United States House Committee on the Judiciary Hearing Entitled
"The Texas Abortion Ban and its Devastating Impact on Communities and Families"

November 4, 2021

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") submit these comments for the U.S. House Committee on the Judiciary, hearing entitled "The Texas Abortion Ban and its Devastating Impact on Communities and Families" held on November 4, 2021.

Planned Parenthood is a leading provider of high-quality, affordable health care and the nation's largest provider of sex education. With more than 600 health centers across the country, Planned Parenthood health centers provide affordable birth control, vaccinations, lifesaving cancer screenings, testing and treatment for sexually transmitted infections, HIV screenings, and other essential care to 2.4 million patients each year. Planned Parenthood's health centers are critical for many underserved communities, specifically communities of color and communities with low-incomes, facing limited access to reliable and affordable health care due to systemic barriers and discrimination.

For over two months, thousands of Texans have been forced to either make costly trips hundreds of miles across state lines to access constitutionally protected health care, or carry pregnancies against their will. S.B 8 bans abortion as early as six weeks into pregnancy in Texas, before many people even know they're pregnant, meaning this law has decimated abortion access in the state. The impact is felt largely by Black, Latino and Indigenous people, those with low incomes, and people in rural areas — who have long faced barriers to abortion access. This is unconscionable. The state of Texas has gone too far, and S.B. 8 has gone on for too long — harming more patients in Texas with each passing day. Every day S.B. 8 is the law of Texas is one more day people are denied the ability to exercise their constitutional rights.

Right now, most people in Texas seeking an abortion are being denied the care they need. Patients are being forced to travel out of state to get an abortion or, if they are unable to travel, carry pregnancies to term against their will. According to a report from the Guttmacher Institute, Texas patients will now have to travel 20 times farther to get an abortion — increasing driving

times an average of 3.5 hours each way. Many Texans are now not able to access abortion unless they can afford to travel hundreds of miles out of state, take time off work, and arrange child care, transportation, and lodging

At the end of October, five Planned Parenthood affiliates in Texas and neighboring states shared stories in an amicus brief filed with the U.S. Supreme Court in the United States' challenge to Texas's S.B. 8, detailing stories of patients being denied abortions and the challenges to health care providers. A shorter version of the brief was filed on October 11 in support of the U.S. Department of Justice's (DOJ) challenge to the radical law that has deprived Texans of the constitutional right to abortion.

Already, people who struggle to make ends meet are often forced to delay abortion services because they need time to secure the funds. Women who have abortions are disproportionately low-income, young, Black and Latina. In 2014, 75% of abortions were among low-income patients, and 64% were among black women or Latinas. In Texas, due to decades of racist economic policies, the poverty rate for Black women and Latinas is disproportionately high, meaning they will be most impacted by this ban. The poverty rate among Black women in Texas is 19%, and is 20% for Latinas. In Texas, 37% of female-headed households live in poverty. Under current law, immigrants must navigate a complicated patchwork of health care coverage that often forces them to pay out-of-pocket for health care services, including abortion. Traveling out-of-state for an abortion is financially, logistically, and emotionally costly, and for many abortion patients — especially those who are Black or Latino, living in rural areas, or have low incomes — the service is out of reach.

For some, cost is just one barrier; immigration status and checkpoint concerns may also inhibit travel. In South Texas, Latino communities and immigrants already face disproportionate barriers to abortion due to long distances, travel restrictions, and border patrol checkpoints scattered along the 100-mile U.S.-Mexico border region. For undocumented women in the region, crossing an inland border patrol checkpoint to get an abortion poses the risk of deportation. Pregnant Texans may also be forced to carry pregnancies to term against their will at risk of their health, in a state with one of the worst maternal mortality rates in the country. Because of structural racism in the maternal health care system and the state's lack of investment in social supports to help Black women and birthing people thrive, they are at a greater risk of dying or suffering severe complications during pregnancy, birth, and the postpartum period.

This law has isolated people seeking abortion — targeting their entire support network and discouraging their loved ones from helping them for fear of being sued. Patients may be scared to have an open conversation about their decision to have an abortion for fear of putting a loved one or other trusted person in legal jeopardy.

Although S.B. 8 is a Texas law, the negative effects are rippling throughout the entire country. In September 2021, Planned Parenthood health centers in surrounding states saw a 1082% increase in patients with Texas zip codes seeking abortion compared to September 2019 and

2020. Since the draconian law has taken effect, and in the days leading up to its effective date, Planned Parenthood of Rocky Mountains (PPRM)'s health centers have seen a significant spike in the percentage of patients traveling from Texas seeking abortions at their health centers in New Mexico and Colorado. There was a 1633% increase in patients with Texas zip codes seeking abortion at Planned Parenthood health centers in Colorado in September 2021, compared to prior years. In September 2021, at Planned Parenthood health centers in New Mexico there was a 48% increase in patients with Texas zip codes seeking abortion, compared to the previous year. On average, the Texas patients that PPRM has seen since S.B. 8 went into effect have traveled approximately 650 miles (one way) to access abortion out of state.

Planned Parenthood Great Plains and Planned Parenthood of Arkansas & Eastern Oklahoma's health centers have also witnessed the devastating effect S.B. 8 has had on Texans and their ability to access abortion. A nurse in Oklahoma, said many patients are 'coming [to Oklahoma] with a sense of desperation.' She recalls a patient who suggested she had been so desperate for the abortion that she would have undergone an abortion performed by someone who was not a 'real' healthcare professional if she had not secured care at the Oklahoma clinic." Similarly, another employee in Oklahoma, similarly reported "seeing Texas patients who drove ten hours through the night, and one patient who said she needed to leave by a certain time in order to get home to ensure her husband did not find out—but the clinic could not guarantee her departure time." The surge of Texans seeking abortions in their Oklahoma health centers since September 1 is unprecedented, and the demand only continues to grow. These demands are causing schedules to become extremely backlogged and there are significant fears from staff that the health center will not be able to continue to serve their existing patient population in Oklahoma in a timely manner given the overflow of patients coming from Texas. During September 2021, Planned Parenthood health centers in Oklahoma saw more than 250 patients with Texas zip codes seeking abortion compared to single digits in the previous year.

It is not just the states geographically touching Texas either. Since S.B. went into effect, in the month of September 2021, Planned Parenthood affiliates saw patients with Texas zip codes seeking abortion travel to Arkansas, California, and as far as New York for care. A southern Illinois Planned Parenthood health care center has served patients from Arkansas, Louisiana, Kentucky, Tennessee, and Texas. Patients are driving over twelve hours to access the health care they need — adding additional barriers such as finding child care, paying long-distance gas mileage, and overnight hotel stays. Kansas does not typically see patients with Texas zip codes seeking abortion, but in Septemer 2021, Planned Parenthood health centers in Kansas saw 31 patients seeking abortion with Texas zip codes. The damage of the Texas law will only continue to spread as the backlog continues. The consequences of this will have severe impacts on patient's lives, forcing them to seek abortions later in pregnancy — which are more restricted and expensive, pressure patients in the surrounding states to scramble to seek care in other states farther away. Many pregnant people without the resources will be forced to carry unwanted pregnancies to term. This extreme law burdens patients seeking the health care they need and the providers, some who are the only providers at their health centers.

Access to abortion is at risk across the country. More than 100 abortion restrictions have been enacted by state legislatures in 2021 alone. In December, the Supreme Court will hear a case about Mississippi's 15-week ban that directly challenges *Roe v Wade*, which protects each person's right to make their own decisions about abortion. We are seeing a surge of abortion restrictions sweeping the country. State lawmakers, emboldened by the new makeup of the Supreme Court and the more than 230 federal judges appointed during the Trump administration, are rushing to control the rights and freedoms of pregnant people. Texas's extremist S.B. 8 law, an unconstitutional six-week ban on abortion, is not an isolated example. It's part of a coordinated attack at the state level to restrict access to safe, legal abortion.

The 2021 state legislative season was the most hostile for reproductive health and rights since *Roe* was decided. According to the Guttmacher Institute, nearly 600 abortion restrictions in 47 states have been introduced this year alone, and 97 of those have been enacted. This already far surpasses 2011 — previously the worst year on record — when 89 restrictions were enacted. But while these attacks are accelerating, they are not new. State legislatures have enacted over 1,320 restrictions in the 48 years since *Roe* was decided, including 580 restrictions enacted since 2011. By July 1 of this year, 8 states had enacted 11 abortion bans, including near-total bans in both Arkansas and Oklahoma; six week bans in Idaho, Oklahoma, South Carolina, and Texas; and reason-based bans in South Dakota and Arizona.

Twenty-six states are poised to move to ban abortion if *Roe v. Wade* were overturned — jeopardizing access for nearly half the country, 36 million women of reproductive age, plus trans men and non-binary people. Today, nearly 90% of American counties are without a single abortion provider, and 27 cities have become "abortion deserts," because people who live there must travel 100 miles or more to reach a provider. There are currently five states with only one abortion provider. 80% of the American public supports legal abortion and there is no state where outlawing abortion is popular.

For many people — especially immigrants, Black, and Latino communities — abortion is already a right in name only and S.B. 8 has deciminated what little access remained. No one is free unless they have control of their own body and future. Every single person deserves access to sexual and reproductive health care, no matter their income, state of residence, zip code, or immigration status. Abortion is normal — nearly one in four women will have an abortion in her lifetime. Abortion is health care. And no one should take the right to access that health care away from you. We must protect safe, legal abortion for anyone no matter how much money they have, where they live, or whether they have insurance.

Sincerely,

Jacqueline Ayers
Senior Vice President of Policy, Campaigns, and Advocacy
Planned Parenthood Federation of America
Planned Parenthood Action Fund
1110 Vermont Avenue NW, Suite 300
Washington, DC 20005

Testimony of the Center for Reproductive Rights

November 4, 2021

House Committee on the Judiciary Hearing

"The Texas Abortion Ban and its Devastating Impact on Communities and Families"

Chairman Nadler, Ranking Member Jordan, and Members of the Committee:

The Center for Reproductive Rights respectfully submits the following testimony to the House Committee on the Judiciary. Since 1992, the Center for Reproductive Rights has worked toward the time when the promise of reproductive freedom is enshrined in law in the United States and throughout the globe. We envision a world in which every woman is free to decide whether and when to have children; every woman has access to the best reproductive health care available; and every woman can make medical decisions without coercion or discrimination. In short, we envision a world in which every woman participates with full dignity as an equal member of society.

One in four women in the United States will make the decision to have an abortion in the course of her lifetime.[1] The right to access abortion is constitutionally protected and has been recognized as such in an unbroken line of cases since *Roe v. Wade* nearly fifty years ago. Yet in large parts of the United States, obtaining abortion care is difficult—and in some cases, impossible—due to a coordinated, nationwide strategy to eliminate access to abortion care.

In September 2021, a draconian anti-abortion law went into effect in Texas, escalating the threat to the constitutional right to access abortion to unprecedented heights. Texas Senate Bill 8 ("S.B. 8") bans abortion after just six weeks—eliminating the majority of abortion access in Texas and effectively making abortion care unavailable to the large number of patients who cannot overcome the logistical, financial, and discriminatory obstacles of traveling out of state to receive care.

But it's not just Texas – states across the country have been chipping away at abortion rights for the past decade, and are newly invigorated by Texas's seeming success in enacting a near-total abortion ban that is currently in effect. Several anti-abortion state lawmakers have already pre-filed similar bills or announced their intention to do so in the next legislative session.

Next month, abortion rights will face yet another challenge when the U.S. Supreme Court hears arguments in *Dobbs v. Jackson Women's Health Organization*, a case in which the state of Mississippi urges the Supreme Court to overturn *Roe* and take away the constitutional right to abortion. This is the first case in which the Court will rule on the constitutionality of a pre-viability abortion ban since *Roe*, putting the continued existence of the constitutional right to abortion at stake.

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[1] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107(12) AM. J. PUB. HEALTH 1904, 1908 (2017), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304042.

I. Our Constitution protects the right of each of us to chart our own life path and to make the deeply personal decisions that impact our lives, our families, and our health, including whether and when to become a parent.

Almost fifty years ago, the Supreme Court recognized the Fourteenth Amendment's liberty protections encompass the right to make deeply personal decisions about whether and when to become a parent. The landmark decision *Roe v. Wade* held that the right to end a pregnancy is fundamental to a woman's personal liberty.[2]

In the following years, the Supreme Court repeatedly reaffirmed *Roe*'s central holding, recognizing that control over one's own reproductive decisions is essential to health, liberty, dignity, and autonomy. In *Planned Parenthood v. Casey*, the Supreme Court explained that "the ability of women to participate equally in the economic and social life of the nation has been facilitated by their ability to control their reproductive lives."[3] In its analysis, the *Casey* Court recognized that, for decades, people have made deeply personal decisions about their lives and their relationships "in reliance on the availability of abortion."[4]

The United States Constitution prohibits the government from enacting any law that bans abortion prior to the point in pregnancy when a fetus is viable and prohibits the government from arbitrarily designating a particular gestational age to establish when viability begins.[5] The gestational age at which viability occurs varies from pregnancy to pregnancy and must be an individual determination for each pregnancy based on a variety of factors.[6] After viability, state abortion restrictions must contain exceptions to safeguard the life and health of pregnant women.[7] The Supreme Court has never wavered from this position, despite numerous opportunities to do so.

II. Access to this fundamental right is in crisis in the United States.

The systematic, sustained effort by lawmakers across the country to chip away at the right to abortion incrementally, restriction-by-restriction, has now reached a crisis point. In the last decade, states have passed more than 550 anti-abortion laws and restrictions.[8] These abortion restrictions work in concert to shape a hostile environment for abortion patients and providers, to close abortion clinics, and to create nearly insurmountable cumulative barriers to abortion access.

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[2] *Roe v. Wade*, 410 U.S. 113, 155, 153 (1973).
[3] *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 835 (1992).
[4] *Id.* at 856.
[5] *See Roe v. Wade*, 410 U.S. 113, 163-64 (1973); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 64 (1976); *Colautti v. Franklin*, 439 U.S. 379 (1979). In *Gonzales v. Carhart* ("*Carhart II*"), 550 U.S. 124 (2007), the law at issue did not ban abortions in general or abortions at any particular point in pregnancy. Rather, it banned only *one abortion procedure*. Although the Supreme Court upheld that law, the Court emphasized that safe alternative abortion procedures were available and explained that its decision was fully consistent with past precedent. *See, e.g., id.* at 146 (stating that the decision is guided by the principle, *inter alia*, that "[b]efore viability, a State 'may not prohibit any woman from making the ultimate decision to terminate her pregnancy,'" (quoting *Planned Parenthood of Se. Pennsylvania v. Casey,* 505 U.S. 833, 879 (1992)).
[6] As a general matter, viability does not exist prior to 24 weeks of pregnancy.
[7] *Casey* at 846.
[8] Elizabeth Nash & Lauren Cross, *2021 Is on Track to Become the Most Devastating Antiabortion State Legislative Session in Decades*, GUTTMACHER INST. (Apr. 2021), https://www.guttmacher.org/article/2021/04/2021-track-become-most-devastating-antiabortion-state-legislative-session-decades#.

As a result of the outsized efforts of state lawmakers to undermine and eliminate abortion access, there has been a drastic reduction in the availability of health care services across vast swaths of our country. Today, nearly 90 percent of American counties are without a single abortion provider,[9] and five states are down to their last abortion clinic.[10] More than twenty-seven cities across the country are "abortion deserts," where patients must travel 100 miles or more to reach an abortion facility.[11]

Fifteen states have also passed near-total bans on abortion, all of which have been blocked by courts or are not in effect—with the exception of Texas S.B. 8. These bans have been passed by: Alabama, Arkansas, Georgia, Idaho, Iowa, Kentucky, Louisiana, Ohio, Oklahoma, Mississippi, Missouri, North Dakota, South Carolina, Tennessee, and Texas.[12]

a. **Texas Senate Bill 8 unconstitutionally prohibits pregnant people in Texas from accessing abortion care.**

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[9] *Data Center: Number of clinics providing abortion by state*, GUTTMACHER INST., https://data.guttmacher.org/states (last visited Nov. 1, 2021).

[10] Holly Yan, *These 6 States Have Only 1 Abortion Clinic Left*, CNN (May 29, 2019), https://www.cnn.com/2019/05/29/health/six-states-with-1-abortion-clinic-map-trnd/index.html. Since the publication of this article, a second clinic has begun offering abortion care in Kentucky.

[11] Alice F. Cartwright et al., *Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search*, 20(5) J. MED. INTERNET RES. e186 (2018), https://www.jmir.org/2018/5/e186/.

[12] Alabama - Act No. 2019-189, Reg. Sess. (Ala. 2019); *Robinson v. Marshall*, 415 F. Supp. 3d 1053 (M.D. Ala. 2019) (striking down near-total abortion ban). Arkansas - Act. 309, 93rd Gen. Assemb., Reg. Sess. (Ark. 2021); *Little Rock Family Planning Services v. Jegley*, No. 4:21-cv-00453-KGB, 2021 WL 3073849 (July 20, 2021). Georgia - Act. H.B. 481 § 1, 115th Gen. Assemb., Reg. Sess. (Ga. 2019); *Women of Color Reprod. Justice Collective v. Kemp*, 472 F. Supp. 3d 1297 (N.D. Ga. 2020), *appeal filed*, No. 20-13024 (11th Cir. Aug. 11, 2020). Idaho - H.B. 366, 66th Leg. Reg. Sess. (Idaho 2021) https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2021/legislation/H0366.pdf . The Idaho law contains a trigger mechanism putting it into effect 30 days after a federal appeals court upholds similar legislation in another state. Iowa - Iowa Code § 146C.2; *see Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. EQCE83074, 2019 WL 312072 at *5 (Iowa Dist. Jan. 22, 2019). Kentucky - Ky. Rev. Stat. § 311.770; *EMW Women's Surg. Ctr. v. Beshear*, No. 3:19-cv-178-DJH, 2019 WL 1233575, at *2 (W.D. Ky. Mar. 27, 2019). Louisiana - S.B. 184, 45th Gen. Assemb., Reg. Session (La. 2019) (enacted "heartbeat" ban that would have become effective had the Fifth Circuit upheld Mississippi's ban). Ohio - OHIO REV. CODE ANN. § 2919.195(A); *Preterm-Cleveland v. Yost*, 394 F. Supp. 3d 796, 804 (S.D. Ohio 2019). Oklahoma - H.B. 2441 of 2021, to be codified at OKLA. STAT. tit. 63, § 1-731.3 et seq. (prohibiting abortion upon detection of a "heartbeat" except in cases of life endangerment or "serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions"). The ban becomes effective on November 1, 2021; *Oklahoma Call for Reproductive Justice et al. v. O'Connor et al.*, No. CV-2021-2072 (D. Ct. Okla. Cnty. Oct. 4, 2021). Mississippi - MISS. CODE ANN. § 41-41-34; *Jackson Women's Health Org. v. Dobbs*, 951 F.3d 246 (5th Cir. 2020) (affirming preliminary injunction of Mississippi's 6-week ban), *cert. granted*, No. 19-1392 (U.S. May 17, 2021). Missouri - Mo. Rev. Stat. §§ 188.056; *Reproductive Health Services of Planned Parenthood of the St. Louis Region, Inc. et al. v. Parson*, No. 2:19-cv-4155-HFS (W.D. Mo. Aug. 27, 2019). North Dakota - N.D. CENT. CODE § 14–02.1-05.2; *MKB Mgmt. Corp. v. Burdick*, 16 F. Supp. 3d 1059 (D.N.D. 2014), aff'd sub nom. *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768 (8th Cir. 2015). South Carolina - The South Carolina Fetal Heartbeat and Protection from Abortion Act, S.1, R-2, Act. No 1 of 2021 ("S. 1" or "the Act"), § 3 (adding S.C. Code Ann. §§ 44-41-610 et seq.); *Planned Parenthood S. Atl. v. Wilson*, No. CV 3:21-00508-MGL, 2021 WL 1060123 (D.S.C. Mar. 19, 2021), appeal docketed, No. 21-1369 (4th Cir. Apr. 5, 2021) (granting preliminary injunction). Tennessee - TENN. CODE ANN. § 39-15-216; *Memphis Ctr. for Reprod. Health v. Slatery*, 2020 WL 4274198 (M.D. Tenn. July 24, 2020). Texas - Tex. Health & Safety Code § 171.204-12.

On May 19, 2021, Texas Governor Greg Abbott signed Texas Senate Bill 8 ("S.B. 8") into law. S.B. 8 bans abortion after approximately six weeks of pregnancy—only two weeks after a person with a regular menstrual cycle has a first missed period. At this stage, many people do not yet even know they are pregnant. This law is a patently unconstitutional attack on the abortion rights of Texans. It is a near-total ban on abortion, with only a single exception for a vaguely-defined "medical emergency." There are no exceptions in cases of rape and incest.

The law deputizes and incentivizes private individuals to sue abortion providers and anyone helping a person obtain an abortion after six weeks of pregnancy; anyone who successfully sues another person or provider will be entitled to a monetary penalty of at least $10,000. This ban is an attempt to force all health centers that provide abortions in the state to close by saddling them with lawsuits that consume their time and resources, and to isolate pregnant people seeking abortions in Texas from their communities and critical support networks.

The law also attempts to circumvent the courts and evade judicial review by encouraging private citizens to enforce the law for them. U.S. Attorney General Merrick Garland called the ban a "scheme to nullify the Constitution."[13]

As a result, abortion care is effectively unavailable to the large number of Texas patients who cannot overcome the logistical and financial obstacles of traveling out of state to receive care. Like all abortion bans and restrictions, the tremendous burdens this law imposes fall hardest on Black, Indigenous, and other people of color, people with disabilities, people in rural areas, young people, and those working to make ends meet, who already face discriminatory and systemic obstacles to accessing health care. Patients have been living in a state of panic, not knowing where or when they will be able to get abortion care.[14]

b. Despite ongoing litigation against this blatantly unconstitutional law, Texas S.B. 8 is currently in effect and imposing irreparable harm on Texans with each passing day.

Texas S. B. 8 was challenged in federal court by Texas abortion providers in July 2021 in *Whole Woman's Health v. Jackson* and has since reached the Supreme Court twice. Plaintiffs first filed an emergency request for relief with the U.S. Supreme Court after litigation was prevented from moving forward in the lower courts. At midnight on September 1, 2021, without action from Supreme Court, S.B. 8 went into effect. Almost twenty-four hours later, the Supreme Court denied the emergency motion for relief, allowing the law to remain in effect and litigation to proceed before the Fifth Circuit Court of Appeals.

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[13] Nick Niedzwiadek & Josh Gerstein, *DOJ sues Texas over abortion law*, POLITICO (Sept. 9, 2021), https://www.politico.com/news/2021/09/09/doj-announces-lawsuit-over-texas-abortion-law-510921.

[14] *See, e.g.,* Katherine Dautrich et al., *Texas abortion ban is an early glimpse of what post-Roe America would look like for women*, CNN.COM (updated Oct. 22, 2021) https://www.cnn.com/2021/10/22/us/texas-abortion-ban-invs/index.html; Iris Samuels, *New Texas abortion law pushes women to out-of-state clinics*, ASSOCIATED PRESS (Sept. 2, 2021) https://apnews.com/article/abortion-lifestyle-health-travel-texas-fbc505c3db4a08af51ba409a91ea161c.

S.B. 8 was temporarily blocked after the Department of Justice ("DOJ") filed a separate federal lawsuit on September 9, seeking to enjoin the law.[15] A federal district court issued a preliminary injunction temporarily blocking S.B. 8 while the DOJ case continued, and for a brief time, abortion providers in Texas began resuming abortion care after 6 weeks. However, shortly after, the Fifth Circuit granted Texas's emergency motion to stay the injunction. S.B. 8 was enjoined for just over 48 hours.

Abortion providers filed a petition for certiorari before judgment, asking the Supreme Court to expedite and consider their case without waiting for the Fifth Circuit to rule. The DOJ filed an application to lift the Fifth Circuit's stay of the preliminary injunction, and suggested that the Court could treat the application as a petition for certiorari before judgment. On October 22, the Supreme Court announced that it would hear both cases—but deferred ruling on DOJ's request to reinstate the preliminary injunction until it heard the cases on November 1. At the time of this writing, the law is still in effect.

In response, Justice Sonia Sotomayor wrote:

> I cannot capture the totality of this harm in these pages. […] [T]he State (empowered by this Court's inaction) has so thoroughly chilled the exercise of the right recognized in Roe as to nearly suspend it within its borders and strain access to it in other States. The State's gambit has worked. The impact is catastrophic.[16]

As Justice Sotomayor noted, S.B. 8 "is causing a 'dismantling of the provider network' across the State".[17] The law is intended to intimidate physicians and other clinic staff out of providing abortion care. If they continue to provide abortion care, they could face ruinous financial penalties, legal costs, and court orders shutting their doors.

According to new research, in the 30 days after S.B. 8 went into effect, the number of abortions in Texas fell by half.[18] The researchers hypothesize that several factors enabled these patients to obtain care despite S.B. 8. These include temporary increases in financial donations after S.B. 8's passage, patients willing to forgo work or school in order to obtain an abortion before they were no longer eligible, and quicker scheduling turnaround due to the decreased number of eligible patients under S.B. 8. The researchers conclude that the number of abortions provided in Texas may continue to decline the longer the law is in effect.[19]

Ten percent of the nation's women of reproductive age live in Texas and are now unable to exercise their fundamental right to access abortion care.[20] This draconian law harms Texans every day,

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[15] Nick Niedzwiadek & Josh Gerstein, *DOJ sues Texas over abortion law*, POLITICO (Sept. 9, 2021), https://www.politico.com/news/2021/09/09/doj-announces-lawsuit-over-texas-abortion-law-510921.
[16] *United States v. Texas,* slip op. at 6, No. 21A85 (U.S. Oct. 22, 2021) (Sotomayor, J., dissenting).
[17] *Id.* at 4 (quoting *United States v. Texas*, No. 1:21-cv-00796-RP, 2021 WL 4593319 at *38 (W.D. Tex. Oct. 6, 2021)).
[18] Kari White, Elsa Vizcarra, Lina Palomares et al., *Initial Impacts of Texas' Senate Bill 8 on Abortions in Texas and at Out-of-State Facilities,* TEX. POLICY EVALUATION PROJECT (Oct. 2021),http://sites.utexas.edu/txpep/files/2021/11/TxPEP-brief-SB8-inital-impact.pdf.
[19] *Id.*
[20] Elizabeth Nash et al., *Impact of Texas' Abortion Ban: A 14-Fold Increase in Driving Distance to Get an Abortion*, GUTTMACHER INST. (updated Sept. 2021), https://www.guttmacher.org/article/2021/08/impact-texas-abortion-ban-14-fold-increase-driving-distance-get-abortion.

disproportionally impacting communities that already face discriminatory obstacles in health care, especially Black, Indigenous, and people of color, undocumented immigrants, those living on low incomes, and those in rural areas. Financial constraints, childcare needs, domestic violence, and immigration status can all prevent people from traveling out of state for health care. For example, people working to make ends meet are often forced to delay accessing abortion services because they need time to secure the funds, and increased transportation costs add an additional financial hurdle.

In Texas, due to decades of racist economic policies, the poverty rate for Black and Latinx women is disproportionately high, meaning they will be most impacted by this ban. Black and Hispanic Texans are more than twice as likely to live below the poverty line as white and Asian Texans.[21] In Texas, 37% of female-headed households live in poverty.[22] Texas prohibits coverage of abortion through its Medicaid program and in nearly all private insurance plans, and S.B. 8 bans anyone—from abortion funds to family members—from paying an abortion provider or providing reimbursement for a patient's care after six weeks, forcing patients to bear the full out-of-pocket cost of their abortion.

c. As a result of S.B. 8, Texas patients are seeking abortion care in neighboring states in record numbers.

S.B. 8 has forced patients who have the means to seek abortion care outside of Texas. Many are traveling hundreds of miles to obtain care in neighboring states. Recent research estimates a 14-fold increase in the driving distance to the nearest abortion clinic—an average of 247 miles each way,[23] assuming that the nearest abortion clinic has appointments available. Oklahoma, Colorado, Kansas, Nevada and New Mexico are already absorbing an enormous influx of Texas abortion patients, and some patients have been forced to secure appointments as far away as Michigan, Florida, New York, and Washington.[24]

These states have reported huge upticks in patients traveling from Texas, often overwhelming local clinics. For instance, an Oklahoma clinic reported that two-thirds of the phone calls they've received since S.B. 8 took effect are from Texas patients. Similarly, an Oklahoma provider reported a "staggering 646% increase of Texan patients per day," occupying between 50% and 75% of capacity,[25] and clinics in Oklahoma have been "forced to delay patients' abortions" for weeks "because of the volume of appointments needed."[26] A Kansas clinic similarly reported that about half of its patients now come from Texas.[27] The District Court found that this "constant stream of Texas patients has created backlogs that in some places prevent residents from accessing

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[21] *Poverty in Texas: 4.1 Million Texans Live in Poverty*, CNTR. FOR PUBLIC POLICY PRIORITIES (Mar. 2019) https://everytexan.org/images/2019_Poverty_in_Texas.pdf.
[22] *See Texas*, Nat'l Women's Law Ctr., https://nwlc.org/state/texas/#:~:text=Poverty.in%20Texas%20live%20in%20poverty (last visited Nov. 3, 2021).
[23] Elizabeth Nash et al., *Impact of Texas' Abortion Ban: A 14-Fold Increase in Driving Distance to Get an Abortion*, GUTTMACHER INST. (updated Sept. 2021) https://www.guttmacher.org/article/2021/08/impact-texas-abortion-ban-14-fold-increase-driving-distance-get-abortion.
[24] *United States v. Texas*, No. 1:21-cv-00796-RP, 2021 WL 4593319 at *42 n. 69 (W.D. Tex. Oct. 6, 2021).
[25] *Id.* at *43 (quoting Yap Decl., Dkt. 8-9 at 3).
[26] U.S. App. to Vacate Stay at 8, *United States v. Texas*, No. 21A85 (U.S. Oct. 18, 2021).
[27] *United States v. Texas*, No. 1:21-cv-00796-RP, 2021 WL 4593319 at *44 (W.D. Tex. Oct. 6, 2021).

abortion services in their own communities."[28] According to recent research, Arkansas, Louisiana, New Mexico, and Oklahoma combined have only approximately half the number of abortion clinics as Texas, and provide about one-third the number of abortions per year.[29]

Many neighboring states to Texas are also hostile to abortion rights and have passed a myriad of restrictions on abortion access, imposing additional barriers on patients who have made the trip from Texas to access their constitutional right to an abortion. For example, Oklahoma recently enacted three extreme abortion restrictions that would force over half of the abortion providers in Oklahoma to stop providing abortions, in addition to other extreme restrictions that would subject patients to significant delays in care.[30] These were temporarily enjoined by the Oklahoma Supreme Court last week while litigation proceeds.[31]

Texas S.B. 8's success in evading judicial review so far has further emboldened other anti-abortion state legislatures to pass additional extreme abortion restrictions. Already, S.B. 8 has had a ripple effect across the country as other states consider how to use S.B. 8 as a model for tougher abortion restrictions. Just this week, Ohio introduced House Bill 480, legislation that imitates S.B. 8's structure for circumventing judicial review and allowing private enforcement of a complete abortion ban.[32] Similarly, Florida legislators have pre-filed a S.B. 8 "copycat" bill for the upcoming legislative session, and Arkansas, Indiana, Missouri, South Carolina, and South Dakota have suggested that they will follow suit.[33] Kentucky, Louisiana, Oklahoma, and more are expected to join them.[34]

d. Beyond S.B. 8, Texas and a majority of states across the country already impermissibly burden abortion access.

In recent years, the stark increase in hostility towards abortion rights has demonstrated a willingness by anti-abortion politicians to do everything in their power to deny patients their constitutional right. Prior to the passage of Texas S.B. 8, abortion was already extremely difficult to access in Texas, where restrictions forced health centers to close, and patients faced countless hurdles, including:

- A 24-hour waiting period after state-mandated biased counseling, which forces patients to make two trips to the clinic and increases their financial burden[35];

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[28] *Id.* at *45.
[29] Kari White, Elsa Vizcarra, Lina Palomares et al., *Initial Impacts of Texas' Senate Bill 8 on Abortions in Texas and at Out-of-State Facilities,* TEX. POLICY EVALUATION PROJECT (October 2021) http://sites.utexas.edu/txpep/files/2021/11/TxPEP-brief-SB8-inital-impact.pdf.
[30] *Lawsuit Seeks to Block Oklahoma's New Abortion Bans and Restrictions,* CTR. FOR REPROD. RIGHTS (Sept. 2, 2021), https://reproductiverights.org/oklahoma-abortion-bans-lawsuit/.
[31] *Oklahoma Call for Reproductive Justice et al. v. O'Connor et al.*, No. 119,918 (Okla. Sup. Ct. Oct. 25, 2021).
[32] Ohio House Bill 480, 134th General Assembly, Regular Session (2021-2022) (Introduced Nov. 2, 2021).
[33] *See* Caroline Kitchener, *Lawmakers are racing to mimic the Texas abortion law in their own states. They say the bills will fly through.*, THE LILY (Oct. 19, 2021), *https://www.thelily.com/lawmakers-are-racing-to-mimic-the-texas-abortion-law-in-their-own-states-they-say-the-bills-will-fly-through/*; *see also* Meryl Kornfield, Caroline Anders, & Audra Heinrichs, *Texas created a blueprint for abortion restrictions. Republican-controlled states may follow suit,* THE WASH. POST (Sept. 3, 2021), *https://www.washingtonpost.com/nation/2021/09/03/texas-abortion-ban-states/*.
[34] *Id.*
[35] TEX. HEALTH & SAFETY CODE § 171.011; *id.* § 171.012.

- Bans on insurance coverage for abortion procedures[36];
- A ban on the use of telemedicine for abortion,[37] and;
- Parental consent requirement for young people in Texas.[38]

Although S.B. 8 already banned abortion care after six weeks in Texas, the state nonetheless passed a new abortion restriction, and another has gone into effect. In August 2021, the Fifth Circuit Court of Appeals became the first federal court in the country to uphold a ban on the standard method of abortion after approximately 15 weeks of pregnancy.[39] In its special session in September, Texas also passed a ban on medication abortion after seven weeks—contrary to FDA guidelines for use —which is set to go into effect on December 2, 2021.[40] Together, these laws will broadly curtail abortion care across the state even if S.B. 8 is rightly enjoined.

Even without the threat of S.B. 8-related bills, we are living in a time of unprecedented hostility towards abortion rights. Texas is not the only state waging a multi-pronged attack on abortion rights to push access out of reach for its citizens. For the past decade, anti-abortion state lawmakers have enacted a coordinated and unrelenting wave of restrictions on abortion access, creating a cumulative undue burden that makes abortion extremely difficult, and sometimes impossible, to access in certain states or even entire regions of the United States, even while *Roe* is still the law of the land. For example, Texas's neighbor Oklahoma: [41]

- bans abortions past 20 weeks of gestation[42];
- bans D&E abortions, the most commonly used abortion procedure in the second trimester (temporarily enjoined)[43];
- bans abortions via telemedicine[44];
- criminalizes self-managed abortions[45];
- aims to force clinics to close through targeted regulation of abortion providers, including facility requirements, and admitting privileges requirements (admitting privileges requirements permanently enjoined)[46];
- imposes biased counseling requirements[47];
- requires parental notification and consent requirements for minors seeking an abortion[48]; and

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[36] TEX. ADMIN. CODE § 354.1167; TEX. INS. CODE § 1218.003; id. § 1218.004.
[37] TEX. HEALTH & SAFETY CODE § 171.063.
[38] TEX. FAM. CODE § 33.0021; TEX. OCC. CODE § 164.052.
[39] *Whole Woman's Health v. Paxton*, 10 F.4th 430 (5th Cir. 2021).
[40] S.B. 4, 87th Leg., 2nd Spec. Sess. (Tex. 2021).
[41] *"What if Roe Fell?"*, CTR. FOR REPROD. RIGHTS, https://maps.reproductiverights.org/what-if-roe-fell?state=OK (last visited Nov. 2, 2021).
[42] OKLA. STAT. tit. 63, § 1-745.5.
[43] OKLA. STAT. tit. 63 § 1-737.9 (A); This law is currently temporarily enjoined. *See* Tulsa Women's Reproductive Clinic, LLC v. Hunter, No. CV-2015-1838 (Okla. Nov. 6, 2019)
[44] OKLA. STAT. ANN. tit. 63, § 1-729.1; S.B. 779 of 2021 ("S.B. 779"), to be codified at OKLA. STAT. tit. 63, § 1-757.1 et seq.
[45] OKLA. STAT. tit. 63, § 1-733; see also OKLA. STAT. tit. 21, § 862.
[46] OKLA. ADMIN. CODE § 310:600-1-1 et seq.
[47] OKLA. STAT. tit. 63, § 1-738.2 (B); Nova Health Sys. v. Pruitt, 2012 OK 103, 292 P.3d 28, as corrected (Okla. 2012) (Oklahoma's ultrasound requirement is permanently enjoined by court order.).
[48] OKLA. STAT. tit. 63, § 1-740.2(B)(1); *Id.* § 1-740.2(B)(3).

- imposes a mandatory 72-hour waiting period before a patient can obtain an abortion.[49]

Oklahoma also recently passed five extreme abortion restrictions that were all set to take effect on November 1. All five have been temporarily enjoined while litigation proceeds.[50] These laws include[51]:

- A law that arbitrarily disqualifies highly trained health care providers like board-certified family medicine doctors from providing abortion because they are not board-certified OB/GYNs[52];
- Two laws that contain a host of restrictions on medication abortion, including an admitting privileges requirement similar to requirements struck down by the U.S. Supreme Court and the Oklahoma Supreme Court[53];
- An ultrasound requirement more restrictive than an ultrasound law already struck down by the Oklahoma Supreme Court[54];
- A total abortion ban, which suspends the licenses of physicians who provide abortion care[55]; and
- A law banning abortion as early as approximately six weeks into pregnancy, before many people even know they are pregnant.[56]

Similarly, neighboring Arkansas' laws:[57]

- generally prohibit abortion at twelve weeks[58] (permanently enjoined) and 18 weeks after the last menstrual period[59] (temporarily enjoined);
- prohibit abortion twenty weeks post-fertilization[60];
- prohibit abortion after viability[61];
- prohibit certain methods of abortion[62];
- ban all abortions (temporarily enjoined)[63];

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[49] OKLA. STAT. tit. 63, § 1-738.2 (B).
[50] *See Oklahoma Call for Reproductive Justice et al. v. O'Connor et al.*, No. 119,918 (Okla. Oct. 25, 2021).
[51] *See Lawsuit Seeks to Block Oklahoma's New Abortion Bans and Restrictions*, CTR. FOR REPROD. RIGHTS (Sept. 2, 2021), https://reproductiverights.org/oklahoma-abortion-bans-lawsuit/.
[52] H.B. 1904, 2021 Okla. Sess. Law Serv. Ch. 211.
[53] S.B. 778, 2021 Okla. Sess. Law Serv. Ch. 577.
[54] S.B. 779, 2021 Okla. Sess. Law Serv. Ch. 578.
[55] H.B. 1102, 2021 Okla. Sess. Law Serv. Ch. 205.
[56] H.B. 2441, 2021 Okla. Sess. Law Serv. Ch. 219
[57] *"What if Roe Fell?"*, CTR. FOR REPROD. RIGHTS, https://maps.reproductiverights.org/state/arkansas (last visited Nov. 2, 2021).
[58] ARK. CODE ANN. § 20-16-1304; The law is permanently enjoined. *See Edwards v. Beck*, 8 F. Supp. 3d 1091 (E.D. Ark. 2014), aff'd, 786 F.3d 1113 (8th Cir. 2015).
[59] ARK. CODE ANN. § 20-16-2002(b); The law is temporarily enjoined. *See Little Rock Family Planning Servs. v. Rutledge*, 984 F.3d 682 (8th Cir. 2021).
[60] ARK. CODE ANN. § 20-16-1405,
[61] ARK. CODE ANN. § 0-16-705 (a).
[62] ARK. CODE ANN. § 20-16-1203; id. § 20-16-1803; The D&E ban is currently blocked by a preliminary injunction. *See Hopkins v. Jegley*, 2021 WL 41927 (E.D. Ark., 2021).
[63] ARK. CODE ANN. § 5-61-404; This total ban is temporarily enjoined. *See Little Rock Fam. Plan. Servs. v. Jegley*, No. 4:21-CV-00453-KGB, 2021 WL 3073849 (E.D. Ark. July 20, 2021).

- ban abortions sought for sex selection and Down syndrome[64];
- require a mandatory seventy-two-hour waiting period[65];
- require biased counseling[66];
- require an ultrasound before obtaining an abortion[67];
- limit public funding for abortions[68] as well as insurance coverage of abortion care under the state's health-care exchange[69];
- require that a parent, legal guardian, or judge consent to a minor's abortion[70];
- aim to force clinics to close through targeted regulation of abortion providers, including facility requirements[71] and admitting privileges requirements[72];
- restrict the provision of abortion care to licensed physicians[73];
- prohibit telemedicine for the provision of abortion care.[74]

These are not isolated instances. Anti-abortion state lawmakers have been trying for years to present a case to the Supreme Court that could overturn *Roe v. Wade*. That case is now being presented to the Court in *Dobbs v. Jackson Women's Health Organization*. In *Jackson Women's Health Organization*, Mississippi brazenly asks the Supreme Court to overturn decades of precedent and overturn *Roe*. This would lay the groundwork for states to take steps towards outlawing abortion entirely. Twelve states have already passed "trigger" bans designed to ban abortion immediately if the Court overturns *Roe*.[75]

Recent research concluded that if the U.S. Supreme Court were to weaken or overturn *Roe v. Wade*, a total of 26 states would be certain or likely to ban abortion.[76] Abortion rights would be protected in less than half of the U.S. states and none of the U.S. territories.[77] Assuming that all 26 states ban all or most abortions, overturning *Roe* would create entire regions of the United States where abortion is banned outright, dramatically increasing the distance patients would need to travel in

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[64] ARK. CODE ANN. §§ 20-16-1904, 20-16-2103; Both provisions are currently enjoined. *See Hopkins v. Jegley*, No. 4:17-CV-00404-KGB, 2021 WL 41927 (E.D. Ark. Jan. 5, 2021); *Little Rock Family Planning Servs.*, 984 F.3d 682 (8th Cir. 2021).
[65] ARK. CODE ANN. § 20-16-1703(b)(1).
[66] ARK. CODE ANN. §§ 20-16-1703(b)(2), 20-16-2403 (a)-(b).
[67] ARK. CODE ANN. §§ 20-16-1703(e), 20-16-1303, 20-16-602(c)(2)
[68] ARK. CONST. AMEND. 68, § 1; In *Hodges v. Huckabee*, the Arkansas Supreme Court held that the state "cannot stand as a bar to the payment of Medicaid funds for abortions necessary as the result of rape or incest so long as the Hyde Amendment as written remains in effect." 338 Ark. 454, 462, 995 S.W.2d 341, 347 (Ark. 1999). Therefore, Amendment 68 is enforced to the limit of federal law.
[69] ARK. CODE ANN. § 23-79-156.
[70] ARK. CODE ANN. §§ 20-16-804, 20-16-809.
[71] ARK. CODE ANN. § 20-9-302; Ark. Admin. Code 007.05.2-8, 007.05.2-12.
[72] ARK. CODE ANN. §§ 20-16-1504(d), 20-19-312. ARK. ADMIN. CODE 007.05.2-8. The Supreme Court denied certiorari, allowing a "contract physician" admitting privileges requirement to go into effect. *See Planned Parenthood of Ark. & E. Okla. v. Jegley*, 138 S. Ct. 2573 (2018
[73] ARK. CODE ANN. § 5-61-101.
[74] ARK. CODE ANN. §§ 20-16-603, 20-16-1504, 20-16-1703.
[75] *"What if Roe Fell?"*, CTR. FOR REPROD. RIGHTS, https://maps.reproductiverights.org/what-if-roe-fell (Nov. 2, 2021).
[76] *If Roe v. Wade Falls: Travel Distance for People Seeking Abortion*, GUTTMACHER INST., https://states.guttmacher.org/ (last visited Nov. 2, 2021).
[77] *"What if Roe Fell?"*, CTR. FOR REPROD. RIGHTS, https://maps.reproductiverights.org/what-if-roe-fell (Nov. 2, 2021).

order to access care. According to the report, if all 26 states ban abortion, the median distance Texans would need to travel to access the nearest abortion clinic would increase to 542 miles.[78] This number does not account for additional scenarios impacting their access, including the possibility that the nearest clinics may not have appointments available or may not provide the type of abortion care they need.

III. Conclusion.

Today, the ability to access abortion care depends on where you live. There are large parts of the country where it is extraordinarily difficult, and in some cases virtually impossible, to access abortion services. For pregnant people in these parts of the country, the constitutional right to abortion is merely theoretical. And when individuals lack access to abortion services, they are harmed. As Justice Sotomayor wrote: "By delaying any remedy, the Court enables continued and irreparable harm to women seeking abortion care and providers of such care in Texas—exactly as S. B. 8's architects intended. […] Every day the Court fails to grant relief is devastating, both for individual women and for our constitutional system as a whole."[79]

The Center for Reproductive Rights, and other litigating organizations such as the American Civil Liberties Union (ACLU) and Planned Parenthood Federation of America, are fighting to protect abortion rights from constitutional challenges across the country. But abortion is facing a crisis on multiple fronts. S.B. 8 only exacerbated an already existing crisis in abortion access in Texas and neighboring, hostile states, where the constitutional right to an abortion is rapidly becoming, or already is, a right in name only. That is especially true for Black, Indigenous and People of Color, rural residents living far from an abortion clinic, people working to make ends meet, people with disabilities, and other populations that experience frequent discrimination in the healthcare system.

Regardless of what the Supreme Court does in *United States v. Texas* and *Whole Woman's Health v. Jackson*, the damage has been incalculable. Already, pregnant people in Texas have been denied their constitutional right to abortion for over two months, and other states are gearing up to follow suit. In her dissent, Justice Sotomayor noted: "S. B. 8 was created to frustrate [the constitutional right to seek abortion care] by raising seemingly novel procedural issues, and it has had precisely the intended effect. … Every day that S. B. 8 remains in effect is a day in which such tactics are rewarded. And every day the scheme succeeds increases the likelihood that it will be adapted to attack other federal constitutional rights."

This multi-pronged crisis requires a swift response from both Congress and the courts. When our constitutionally protected liberties are under sustained attack, Congress has a responsibility to enact legislation to safeguard those rights. We need Congress to act now—because the crisis is now. We applaud the House of Representatives for two historic votes to advance reproductive rights this session: passing the Women's Health Protection Act and passing an appropriations bill free of the Hyde Amendment and related restrictions on coverage of abortion care. The Women's Health Protection Act would protect the provision of and access to essential reproductive health care and the constitutional rights of all people to access abortion, no matter where they happen to live. An appropriations bill free of the Hyde amendment would ensure that the government no

[78] *Id.*
[79] *United States v. Texas,* slip op. at 2, No. 21A85 (U.S. Oct. 22, 2021) (Sotomayor, J., dissenting).

longer denies coverage of abortion care under Medicaid and pushes that care out of reach for people who are struggling financially—people who are more likely to be women of color, young, immigrants, and members of the LGBTQ+ community. Both bills are now in the hands of the Senate. At this key moment, as pregnant people across Texas—and beyond—remain unable to access to their constitutionally protected right to access abortion, all steps must be taken to support abortion access for all who need it.

Ms. Foxx. I thank Ranking Member Comer for yielding. Those of us on our side of the dais see this as a very solemn day. It appears that the purpose of this hearing is to normalize the destruction of unborn babies, which is called abortion. Let me say at the outset that I feel profound sorrow for any woman who believes that she must destroy her unborn child, and I certainly extend that to our colleagues here today. Instead of glorifying this awful act of desperation, we ought to grieve for the tens of millions of Americans who never had a chance to take their first breath, to see their mother's face, or even to cry for help.

Children in the womb are people. They are our sons, daughters, future teachers, future members of Congress. They are innocent lives who do not deserve death. I refuse to normalize abortion and reject its very premise that the sacrifice of an innocent life that cannot speak for itself is justified in any way. We live in a society that mistakes choice for liberty and deny the dignity of unborn life, but the beauty of living in a free country is that we can use our liberty for love. We must put love into action every day, affirming the value of life at all stages, no matter the difficulties it presents.

Striving to love daily is not easy, yet it is the greatest exercise of our freedom, and there is no life unworthy of that

love. Those who are attempting to normalize the destruction of the innocent unborn do so through language that denies what they are doing. Today we will hear many terrible euphemisms -- we have already heard them -- for the slaughter of children. Allow me to define some of the terms. Women's health: abortion or destruction of innocent unborn babies. And how can this be true when half the babies aborted are female? Reproductive freedom: the ability to murder a child out of convenience. Abortion rights: robbing another of life. Pro-choice: destroying innocent life.

It is important that we not allow these terms to obscure what is happening to millions of unborn babies. It is becoming a common refrain for many women to say that "I wouldn't be the person I am today if I had not had an abortion." Well, I can tell you that Representative Kat Cammack literally would not be the woman she is today because of abortion. She would not be with us and those of you who promote abortion would not be with us if your mothers had had an abortion. We should grieve for the millions of children whose lives were ended because they were not wanted.

Whether a pregnancy is planned or unplanned or even the result of horrific circumstances, ending that child's life with an abortion to empower or protect the "freedom" of the mother is not answer. Abortion only compounds the sorrow. How can any

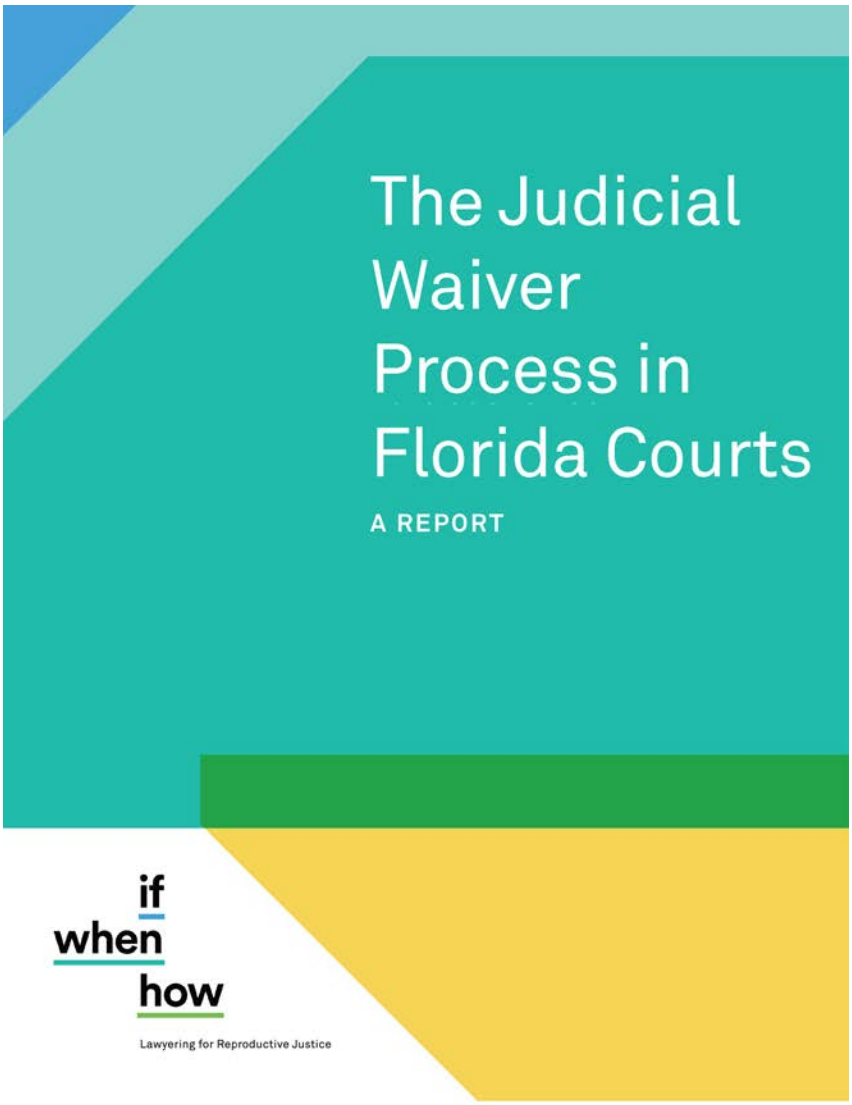
woman say that her life is better because of abortion? Who is anyone to say that? Has she looked into the future and seen all the possible arcs of her life? Has she seen the future of her unborn child's life and all the possibilities that life held? Has she determined that her child's life is not worth living?

Abortion is not prideful. It is not a form of empowerment. Motherhood is empowerment. Only women have the ability to bring life into the world. Abortion is robbing a woman of motherhood and robbing a human being of God's most precious gift: life. Life is the most fundamental of all rights. It is sacred and God given, but tens of millions of babies have been robbed of that right in this, the freest country in the world. This is a tragedy beyond words and a betrayal of what we as Nation stand for. Before liberty, equality, free speech, freedom of conscience, the pursuit of happiness, and justice for all, there has to be life, and yet for millions of aborted infants, many pain capable and many discriminated against because of gender or disability, life is exactly what they have been denied. And an affront to life for some is an affront to life for every one of us.

One day we hope it will be different. We hope life will cease to be valued on a sliding scale. We hope the era of elective abortions ushered in by an unelected Court will be closed and collectively deemed one of the darkest chapters of

American history, but until that day, it remains a solemn duty to stand up for life. Regardless of the length of this journey, we will continue to speak for those who cannot, and we will continue to pray to the One who change the hearts of those in desperation and those in power who equally hold the lives of the innocent in their hands. May we, in love, defend the unborn. May we, in humility, confront this national sin. And may we mourn at what abortion reveals about the conscience of our Nation.

I yield back.


The Judicial Waiver Process in Florida Courts
A REPORT
if when how
Lawyering for Reproductive Justice

Contents

if
when
how

This Report was authored by Stephanie Loraine Pineiro, MSW, consulting for If/When/How: Lawyering for Reproductive Justice and Erin Carroll, MPH, with the Center for Reproductive Health Research in the Southeast. This Report would not be possible without the invaluable assistance of volunteers from partner organizations, including Planned Parenthood of North and South Florida, Florida Access Network, Penn Law's If/When/How Student Chapter, and Power U: Center for Social Change, who worked with Ms. Pineiro to collect the data for this report.

This report is modeled on similar studies including a report published in Michigan.[1]

INTRODUCTION

Across the United States, people face extraordinary barriers when seeking abortion care. For young people under 18, those barriers are compounded when they are forced to involve their parent(s) or legal guardian.[2] If a young person cannot involve a parent, their only other option is to seek permission from a court to access abortion care in lieu of parental involvement; this process is referred to as a judicial waiver or bypass.

YOUNG PEOPLE'S ACCESS TO ABORTION IN FLORIDA

The law in Florida requires parental notification before a young person under 18 years of age can access abortion care.

Florida's Parental Notice of Abortion Act (PNA)[3] requires one parent be given actual or constructive notice of the young person's decision to have an abortion at least 48 hours before the procedure.[4] A parent may waive the notice requirement in writing with notarization. Notice is not required if the young person has been married and provides a marriage certificate or divorce decree; has a dependent child and provides the dependent child's birth certificate naming the young person as the parent; or is legally emancipated and provides documentation. The notice reqirement may also be waived in a medical emergency, as determined by the physician, or if the young person has been granted judicial waiver by the court.

A judicial waiver permits a young person to bypass the notification requirement.

[1] *Michigan Youth Rights: The Assessment; A look into the judicial bypass process in Michigan.* A report by the Michigan Organization on Adolescent Sexual Health 2015

[2] Parental involvement laws require young people to involve a parent (in some states both parents) or legal guardian before they can access abortion care. For the sake of brevity we will use the term parent for both parent or legal guardian.

[3] FL Statute 390.01114

[4] Actual notice means in person or by telephone. Constructive notice means in writing. Seventy-two hours in advance of the procedure is required for constructive notice, 48 hours for actual notice. In addition, the Florida statute requires notice to be given either by the physician who will perform the abortion or a referring physician.

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A judicial waiver of notice must be filed in the county where the young person resides. The waiver is granted if the court finds that the young person is sufficiently mature to decide whether to terminate their pregnancy or that the notification is not in the young person's best interest. The notification requirement may also be waived if there is evidence of child abuse or sexual assualt by a parent or guardian.

Once the petition is filed, the court has three business days to issue a ruling on the petition. If there is no ruling, another petition can be filed with the Chief Judge of the Circuit to ensure there is a hearing held within 48 hours of the second petition.

The judicial waiver process is the only option for a young person to access abortion care if they are unemancipated and cannot involve a parent. Youth in foster care and those who are not in contact with a parent have no choice but to navigate the judicial waiver process in order to access abortion care. Regardless of whether a young person is living with a trusted adult or other family member, if that adult is not their parent or legal guardian, they would still need to obtain a judicial waiver to access abortion care.

THE COURT'S ROLE

County courthouses and clerks of court are relied on as a resource for young people seeking judicial waiver to the notification requirement

There are few resources for young people in Florida about the judicial waiver process, and those who need a waiver are generally referred to the clerk of court in their county.

The National Partnership for Women and Families (NPWF) published a legal guide for pregnant youth in 2009 which includes information about accessing abortion care and an outline of the waiver process.[5] The guide states that young people can go directly to the clerk of court's office in the courthouse, but notes that the process is often easier if the young person connects with an attorney first. However, the guide is outdated with regard to services, directing young people to websites and programs that are no longer in operation.

A young person who seeks a judicial waiver is entitled to a court appointed attorney at no cost. However, for the court to appoint an attorney the young person must first contact their county clerk and start the process to file a petition. The information a young person gets regarding the waiver process may vary, and this can greatly impact their experience throughout the process or even their ultimate ability to access an abortion.

[5] "Legal Guide for Pregnant Teens in Florida" http://www.nationalpartnership.org/our-work/resources/repro/adolescent-health/legal-guide-fl-pregnant-teens.pdf

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COURT PREPAREDNESS

METHOD

The project coordinator reviewed other studies and a published report from Michigan on court staffs' responsiveness to calls for information on judicial bypass[6] and prepared a script and answer classifications based on those studies. Prior to recruiting volunteers, test calls were made to randomly selected courthouses in counties around the state in order to get a sense of the responses callers could expect. Volunteers were recruited online through If/When/How law student chapters, through contact with coalition members whose interns volunteered to participate, and individuals known to the project coordinator. In all, 6 volunteers participated in the project. When a call was completed, the caller filled out a response form in which they rated each county based on nine criteria to indicate overall preparedness (see attached questionnaire). The caller also recorded their initial response to the call, how many extensions they had to go through to reach someone, how many times they called, the number of times they were transferred, the total duration of the call, and the department they called or from which they received information.

ANALYSIS

At the completion of the calls, the project manager gathered summary statistics for all variables to demonstrate the percentages for each response callers received on the nine criteria used to measure preparedness. Using this data, counties were then labeled prepared, semi-prepared, unprepared, or unable to contact. Counties labeled prepared demonstrated sufficient enough knowledge in the process that someone seeking information could reasonably file a petition for a judicial waiver based on the information provided by court staff. Counties labeled semi-prepared demonstrated a limited amount of knowledge in the process or aspects of it (for example, whether the proceedings would be kept confidential or if a young person could access an attorney free of charge) but did not provide enough information that someone seeking a judicial waiver would feel sufficiently prepared for the process prior to filing the petition. Counties labeled unprepared demonstrated no knowledge of the process or indicated a judicial waiver would not be possible in the county. Counties were labeled unable to contact if callers were unable to reach court personnel to answer their questions.

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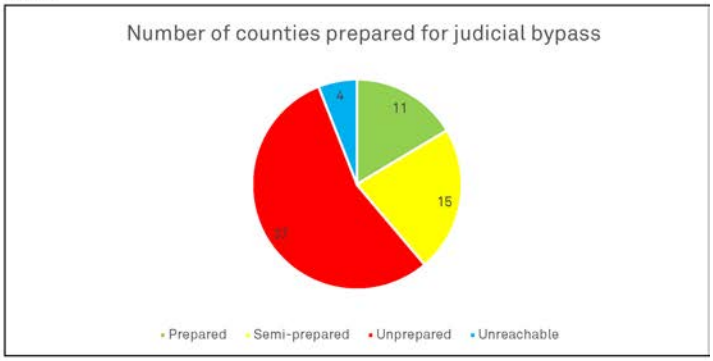
[6] *Michigan Youth Rights: The Assessment; A look into the judicial bypass process in Michigan*. A report by the Michigan Organization on Adolescent Sexual Health 2015

County data was further broken down for analysis using demographic data from the American Community Survey five-year population estimates for females between the ages of 15-17. This enabled analysts to evaluate the effect, if any, of population most affected by parental notification laws on county preparedness. Similarly, counties with abortion clinics were identified to determine whether having a clinic or clinics affected preparedness.

RESULTS

The call durations ranged from under one minute to over 30 minutes. Participants often described having to wait through multiple holds, either while waiting for someone to pick up the phone or while court personnel searched for answers to their questions. The average call time for prepared courts was approximately nine and a half minutes, while the average time for semi-prepared was almost 11. By contrast, the call time for unprepared courts was a little over 5 and a half minutes. Callers were typically only transferred once, but a few were transferred up to 3 times, with no variance between prepared, semi-prepared, and unprepared courts. The departments that callers reached varied, with some callers able to get information from someone answering a courthouse's main number to one who only received answers when she was transferred to the criminal court division. In the case of prepared counties, typically the juvenile or family court division provided the necessary information.

Table 1



Prepared counties

Of Florida's 67 counties, 11 (16%) were classified as prepared or knowledgeable about the process. Though several counties were unable to sufficiently answer all the indicators used to determine preparedness, an overall awareness of how the process worked and general information about time, costs, and attorney and translator availability was enough for analysts to assume a young person calling about judicial waiver would be able to get the information they needed to proceed. The comment by a caller who reached someone with some knowledge of the process is typical of other similar calls:

> *"When I called the number, I was not sure what option to select because there was no option for juvenile services. I spoke with main operator who transferred me to Family Court. The person who answered was not too familiar with the process and stated they don't 'get too many requests for this.' She put me on hold and was [sic] transferred me to Juvenile division. When I spoke to the person in this department, she informed me I needed to come in person to the courthouse to pick up the forms that I needed to start the process. She was unsure of how long the process would take, so she put me on hold again. She then informed me that after I filed the paperwork, I would be called in for a hearing immediately (within 72 hours, give or take). I would then be notified of a court date. She indicated where I needed to go to pick up the paperwork (forms). She then informed me that the process was confidential and not would not cost me anything. Although she appeared to not have all the information I needed on hand, she made every attempt to help me."*

Some counties demonstrated preparedness without much prompting. For example:

> *"The clerk who answered was very knowledgeable about the procedure and was able to answer all of my questions, even providing detail about the procedure (ex. the judge must issue a ruling within 24 hours of hearing). When I asked about information for a non-English speaking person he told me the forms were only available in English so I would need someone to help fill those out but that at the hearing the court could have an interpreter present. He also told me that there were only a few people trained in the procedure in the Clerk's office so he would make sure one of them was around for the rest of the day in case I decided to come in; I found this very helpful and thoughtful."*

Overall, callers who found the court personnel knowledgeable generally commented on the helpfulness of the staff with whom they interacted. One clerk went so far as to offer

advice to the caller that they should visit a Planned Parenthood to get counseling before coming to court because the judge would ask about that. Another provided the caller with the number of the attorney in the county who handles judicial bypass cases so she could provide additional guidance for the process.

Semi-prepared counties

Fifteen (22%) counties were classified as semi-prepared in the judicial bypass process. Court staff who were semi-prepared typically demonstrated a degree of knowledge about aspects of the process, but were unable to provide information sufficient enough to assume a young person would be able to proceed with the information provided. For example, a caller who connected with someone in the family law division found that:

> *"The woman who answered told me that the clerk who usually would have that information was out for the week but that she would try to help me as much as she could. She put me on hold for a while while she researched the statute and read the Notice and Petition for the procedure. She was able to answer most of my questions and was very apologetic that she didn't know more."*

Most of the semi-prepared counties told callers they would need to come in to the courthouse to give them information about the process. The experience of a caller who spoke to someone at a main courthouse line is typical of the responses others received from these counties:

> *"I spent most of the 16 minutes either on hold waiting for someone to pick up my call or just waiting while she seemingly looked up the procedure. She didn't really know anything and when I finally got information it was just along the lines of 'you have to come in in person, fill out a form, we will schedule a hearing.' I asked the first question-- will her parents be notified-- and she didn't know. She tried to find info online but after a while just said I should come in."*

Counties were also classified as semi-prepared if they were able to answer some questions but provided incorrect information. For example, one clerk advised a caller that she would be able to file a judicial bypass petition in a county other than the one in which she resided, but the statute explicitly states that minors must seek a bypass in the county in which they reside. Some counties were also classified as unprepared if they were able to relate to the caller all the details of the bypass except for the fact that the young person is entitled to an attorney free of charge.

Unprepared counties

Thirty-seven (55%) counties were classified as unprepared to assist a minor in the judicial bypass process. Typically, these counties could offer very little information to the caller about how the process worked; often court personnel said they had never heard of judicial bypass and were unable to answer questions regarding confidentiality, obtaining an attorney free of charge, or how the process works for non-English speakers. Many staff members told callers that they would need to contact a private attorney, and while some offered the number for legal aid organizations, others provided little direction for how a young person would go about retaining an attorney. For example, *"The woman I spoke to had no idea what I was talking about. She said I needed to get an attorney but I wouldn't be able to get one through them."*

Some court personnel in unprepared counties gave legally inaccurate information to callers, like the assertion made by one clerk in a Family Court that a minor could only obtain an abortion without parental consent if they were legally emancipated from their parents. Still others responded to the callers' questions by asking if the caller had considered alternatives to abortion. For example, a caller who spoke to someone at the main courthouse number said *"The person was very rude and tried to give me information on adoption. She said she could give me information on alternatives to abortion if I wanted them."*

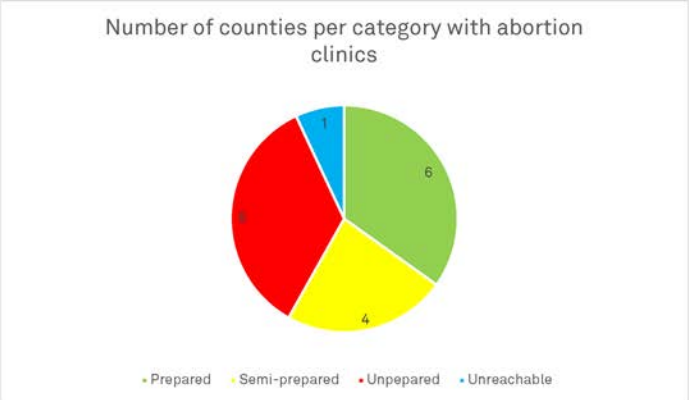
Directing callers to an abortion clinic for information was typical of unprepared courts. In many cases court staff were able to answer questions about confidentiality and costs, but in others they suggested coming in in person or calling a specific judge's office. In two calls, staff refused to answer any questions over the phone. For example, a caller reached a juvenile court clerk after three attempts and said that:

> *"The woman who picked up said that I had to come in person to the office. She wouldn't answer any questions on the phone because she said they are not allowed to give information on the phone. When I asked where I could find more information she said I could maybe try Planned Parenthood."*

Unable to be reached

Four (6%) counties were unable to be reached when callers were calling courthouses. When callers called three of the four counties they were given numbers or transferred to other numbers where they were unable to reach a person to whom they could direct their questions. A call to a fourth county was never answered by personnel or a machine.

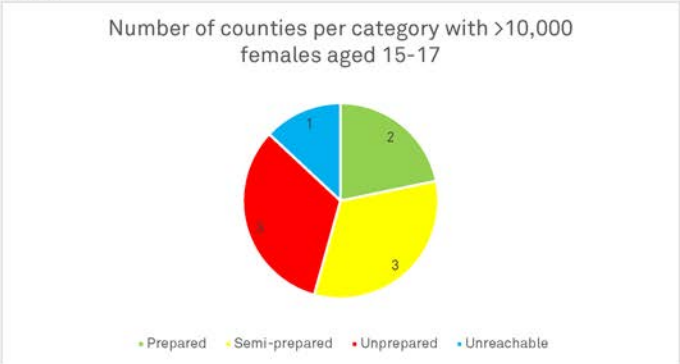
Table 2



Counties with abortion clinics

Seventeen counties in Florida have at least one abortion clinic. Of those, six (35%) were classified as prepared, four (24%) were classified semi-prepared, 6 (35%) were unprepared, and one (6%) was unable to be contacted. Of the eleven counties classified as prepared six (54%) had at least one abortion clinic operating in the county. Of the 15 semi-prepared counties, four (27%) had abortion clinics. Of the 34 unprepared counties, six (18%) had abortion clinics. Only one (6%) county with an abortion clinic was unable to be reached.

Table 3



Counties by population of females aged 15-17

Nine (13%) counties in Florida have over 10,000 females between the ages of 15 and 17. Of those nine, two (22%) counties were classified as prepared, while three (33%) were semi-prepared, three (33%) were unprepared, and one (11%) was unable to be reached. The average population of females aged 15-17 for both prepared and semi-prepared counties was over 6,000, while the average for unprepared counties was nearly 4,000.

LIMITATIONS

There were a few limitations to this study. First, the volunteer callers were not asked to follow-up or make additional calls if they were unable to get sufficient information during their initial call. There is some indication that when callers pursued referrals they were more likely to obtain the necessary information to initiate a judicial bypass.

Second, callers' ages ranged from 17 to 45. There is no indication that court personnel made assumptions about who a caller was calling for, but it is possible that some bias may have been introduced if court staff ascertained that they were speaking with an adult, rather than a person under 18 years of age.

DISCUSSION

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Overall, a majority of counties in Florida did not demonstrate that they are prepared to sufficiently assist a young person seeking a judicial bypass. While many suggested that the caller call an abortion clinic, which could have yielded information on the process, ultimately a young person seeking a bypass would have ended up either having to call the courthouse again or go in person to file the petition. Additionally, there is no indication that clinics would have a better sense of the process than the staff charged with facilitating it in courthouses.

Though not universal, callers typically found that calls to prepared and semi-prepared counties were "smooth" and staff to be "kind" and "wonderful." By contrast, while calls to some unprepared counties were "not very bad," one caller found the court staff person with whom she spoke to be "very rude" and another classified another unprepared county as "the worst call I did." In a few cases where callers were referred to other divisions or told to call back, they were unable to do so and thus did not obtain sufficient information. In one particular county, the person who initially answered the phone had never heard of a judicial bypass and asked another person in the room what the caller needed to do. The person they asked seemed to indicate knowledge of the process, as the original staff person returned to the phone and gave the caller a name and number to call. It is unknown whether calling that number would have resulted in getting necessary information.

Another issue encountered by callers across preparedness levels was the overall lack of awareness on the part of court staff. It is likely that for the vast majority of young people calling for information on judicial bypass, that call will be their first encounter with the court system. In several calls when the person who answered was uninformed about the judicial process, they made it clear that they wanted to assist the caller, and in a few looked up the statute and attempted to walk the caller through the process while they read it aloud. In many cases, however, callers were interrupted, talked over, or hung up on.

One consistent feature of calls across preparedness level was that one person in a courthouse seemed to be the designated person to discuss judicial bypass. If that person was available, the caller was able to get the information they would need to successfully submit a petition. If that person was not available, the caller's experience varied: sometimes the person who answered would attempt to get the information they needed in order to assist them, other times it was suggested they call back when the person would be available. In one instance, the caller was told to call back when the person who handled judicial bypass cases returned from vacation, but was never told the person's name.

A final issue that arose during the calls was the not-uncommon request that a caller leave a name and number so they could be called back after the necessary personnel returned or the information the caller required was obtained. This practice has the possibility of compromising a young person's privacy at a time when it is most necessary to protect it. There may be times when a call back to a young person is required, but there is no mention that the person asking to call back encouraged the caller to use a pseudonym or ensured that the number they would be calling is a private number inaccessible to anyone besides the young person or someone they trusted.

RECOMMENDATIONS

To improve access to abortion care for young people in Florida, courts must provide clear, consistent, accurate, and unbiased information about the judicial waiver process

Florida courts are overwhelmingly unprepared to answer questions about the judicial waiver process. Court staff's inability to provide accurate and unbiased information compromises young people's right to abortion access, which is protected under the Florida Constitution.[7]

Florida courts should make clear, consistent, accurate, and unbiased information about the judicial waiver process readily accessible to the public to ensure young people can access the waiver process. The Office of the State Courts Administrator oversees Florida's 67 Clerk of Court offices and should be responsible for the development and state-wide implementation of guidelines to standardize courthouse responses to questions about the judicial waiver process. Court staff, including Clerks of Court, should be trained to provide accurate, unbiased information when asked about the process or when a young person appears in court to file a petition in person.

Such measures may include:

a) A step-by-step guide detailing the procedures for judicial waiver from the initiation of a petition for judicial waiver to a court's final ruling, and, if applicable, by county, an expected timeline for proceedings; where the minor can locate and obtain materials, physically or online; where and how a petition and any necessary paperwork may be filed; and a list of important deadlines.

[7] Article X, Section 22, FL Constitution. The Florida Constitution required an amendment to allow parental notification and required the Legislature to provide exceptions such as the judicial waiver process.

b) A list of each county's clerk of court, including addresses, current business hours, and the direct contact information for a staff member who is familiar with the judicial waiver procedures in a particular circuit's jurisdiction.

c) Information about how to access the names and contact information for attorneys who provide services on a pro bono basis to minors seeking a judicial waiver.

d) Information about the evidentiary standard that the court is required to use when deciding whether to grant or deny a judicial waiver, including a list of evidence the minor must provide to the court during the hearing.

e) The Office of State Courts Administrator must provide an adequate amount of published materials in hard copy to each clerk of court and to each health care provider that offers abortion services which includes all of the information regarding judicial waiver procedures.

f) The Office of State Courts Administrator must publish a clearly visible hyperlink on its website that directs the public to a standalone webpage, which may not share a uniform resource locator (URL) with any other information, containing all of the information required.[8]

[8] Recommendations a-f were part of an amendment to HB 1335: Parental Notice for Abortion, introduced by State Representative Anna V. Eskamani in the 2019 legislative session, which would have codified the Office of the State Courts Administrator's responsibility to provide the above recommendations.

if when how

APPENDIX

COURTHOUSE CALL QUESTIONNAIRE

Volunteer: "Hi, I am calling to find out how a girl who is not 18 who wants an abortion can get a judge's permission to avoid telling her parents. (If unaware of judicial bypass process, proceed straight to question 8)"

1. How does she start? What will she have to do to get the judge's permission?
a. Knowledge of process, requirements, and details
b. Unfamiliar with process, unable to provide details
c. Denial of procedure through judge, rejection

2. So, her parents will not be notified?
a. No, they will not be notified
b. Yes, they will be notified
c. Not sure

3. Will everything remain confidential?
a. Yes, it will remain confidential
b. No, it will not remain confidential
c. Not sure

4. Is there any kind of public record of the event?
a. No, it will be sealed
b. Yes, there will be a public record
c. Not sure

5. This sounds like a complicated process. Is there somebody who can help her with it? Does she need a lawyer?
a. No, she has a right to court-appointed counsel
b. Yes, she will need a private lawyer
c. Not sure

6. Will it cost money?
a. No, there will be no costs to her
b. Yes, it will cost her money
c. Not sure

7. How long will the process take?
a. Will be handled within 5 business days
b. Unspecified, long time
c. Not sure

8. Where can I get information about this process?
a. Abortion Clinic
b. Clerk website
c. In-person
D. Not sure

9. Where can someone get information if they do not speak English?
a. Translator available
b. Not sure

if when how

PREPAREDNESS BY COUNTY

Unable to Reach	Female Population 15-17 years old	Counties with Clinics
Baker County	622	
Broward County	35,209	✓
Levy County	652	
Marion County	5,493	

Prepared Counties	Female Population 15-17 years old	Counties with Clinics
Alachua County	3,739	✓
Bay County	2,973	
Clay County	4,728	
Duval County	16,059	✓
Flagler County	1,701	
Hamilton County	215	
Hernando County	3,138	
Lake County	5,530	
Lee County	11,137	✓
Seminole County	9,022	✓
St. Lucie County	5,469	✓

Semi-Prepared Counties	Female Population 15-17 years old	Counties with Clinics
Bradford County	429	
Brevard County	9,593	
Calhoun County	508	
Citrus County	1,930	✓
Desoto County	552	
Hardee County	518	
Hillsboro County	25,718	✓
Indian River	2,359	
Leon County	4,493	✓
Martin County	2,529	✓
Okaloosa County	3,263	
Okeechobee County	542	
Orange County	24,743	
Palm Beach County	24,329	✓
Pasco County	8,982	

if when how

Unprepared Counties	Female Population 15-17 years old	Counties with Clinics
Charlotte County	2,217	
Collier County	5,400	✓
Columbia County	1,304	
Dixie County	227	
Escambia County	5,273	
Franklin County	106	
Gadsden County	759	
Gilchrist County	331	
Glades County	112	
Gulf County	236	
Hendry County	804	
Highland County	1,528	
Holmes County	281	
Jackson County	774	
Jefferson County	122	
Lafayette County	174	
Liberty County	72	
Madison County	305	
Manatee County	6,001	
Miami-Dade County	46,425	✓
Monroe County	922	
Nassau County	1,370	
Osceola County	7,220	✓
Pinellas County	14,220	✓
Polk County	12,416	✓
Putnam County	1,352	
Santa Rosa County	3,297	
Sarasota County	5,431	✓
St. Johns County	4,599	
Sumter County	696	
Suwannee County	595	
Taylor County	337	
Union County	256	
Volusia County	8,228	
Wakulla County	567	
Walton County	841	
Washington County	377	

if when how